STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315268	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven Health Care Center	120 Park End Place East Orange, NJ 07018

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following:On 08/19/2025 from 09:33 AM until 10:09 AM, the surveyor observed the following in the kitchen in the presence of the Director of Dietary (DD): 1.In the freezer #1 a large block of pepper jack cheese was wrapped in clear plastic with no label and no date. The DD said that the staff cut a smaller piece off the cheese and labeled the smaller piece but not the large block. She stated the cheese should have been labeled and dated. 2. In the prep area on bottom shelf there was a metal bin of prepared cookies next to one red and one green wash and sanitize buckets. The DD said the best practice is to have them separated. 3. In the milk box, the inside thermometer reflected a temperature of 50 degrees Fahrenheit (F). There were approximately 45 small boxes of whole milk and 12 small boxes of skim milk. The DD checked the temperatures of 3 random milk boxes the temperatures ranged from 46 degrees F to 51 degrees F. The DD stated the temperatures of the milk is too high. She stated that she will discard the milk and repair the milk box. 4. In the walk-in freezer there was a bag of diced green peppers with no label and no date. The DD said the peppers were removed from a box and once removed should be labeled and dated. There was an opened bag of frozen eggplant with no label and no date. The DD said the eggplant should have an opened date. She said she will discard the eggplant. There was a box of pierogies with ice on top of the box. The box was dated 2/17/25. The DD stated the pierogies are good for 6 months and she will discard the pierogies. The surveyor reviewed the facility provided policy titled, Labeling and dating System Protocol with no date which reflected: all fresh and frozen foods must be dated with the date it was received into the kitchen and all food in freezer storage 6 months, all opened frozen item must have expiration date of 6 months. The surveyor reviewed the facility provided policy titled, Milk Holding Box with no date which reflected the holding box fridge is monitored for temperature twice a day, morning and evening shift and temperature above acceptable range must be reported to the food service director or to the immediate supervisor. NJAC 8:39-17.2(g)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and facility provided documentation, it was determined that the facility failed to ensure all medications were stored in accordance with professional standards by having expired medications in 2 of 2 medication storage rooms inspected. This deficient practice was evidenced by the following: On 08/21/2025 at 10:42 AM the surveyor in the presence of a Register Nurse (RN)# 1, observed a bottle of Sodium Chloride salt tablets (a medication used to replenish low sodium levels in the body) that had and expiration date of 5/2025. The surveyor also observed a bottle of Aspirin 325 mg (a medication commonly used to treat pain) that had an expiration date of 6/2025 in the 3rd floor medication storage room. The RN # 1 removed the two items and said there should not be expired medications in the medication room.On 08/22/2025 at 09:28 AM the surveyor in the presence of the Unit Manager Licensed Practical Nurse (UMLPN) #1, observed a 50 milliliter (ML) 0.9% sodium chloride injection bag (a sterile solution for intravenous administration after admixture with a single dose powdered or liquid drug vial) that had an expiration date of 06/2025. The UMLPN #1 said, I usually clean out the med room on Fridays, there should not be anything expired in hereDuring an interview on 08/22/2025 at 10:35 AM with the surveyor the Director of Nursing (DON) said that there should not be expired items in the medication storage room.A review of a facility provided policy last reviewed on 1/2024 titled, Medication Labeling and Storage revealed, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.N.J.A.C 8:39-29.4 (g)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to provide appropriate and sufficient supervision to a resident to prevent an avoidable accident specifically by leaving an unattended cup of medication tablets in a resident's room. The deficient practice was identified for 1 of 2 (Resident 60) Residents review for Accidents. The deficient practice was evidenced by the following: A review of Resident # 60's annual Minimum Data Set (an assessment tool) located in the Electronic Medical Record dated 06/08/2025 (EMR) revealed that he/she had a Brief Interview of Mental Status score of 2/15 indicating that Resident # 60 was severely cognitively impaired. A review of Resident # 60's EMR revealed under Diagnoses, that he/she had a diagnoses of but not limited to unspecified dementia. On 08/19/2025 at 9:30 AM during the initial tour, the surveyor observed Resident # 60 in their room. At that time, the surveyor observed four tablets in a cup on the resident's bedside table. At that time, the surveyor spoke to the Registered Nurse/Unit Manager (RN/UM). The RN/UM stated the nurse should not have left the medications at the resident's bedside. On 08/22/2025 at 10:48 AM during an interview with the surveyor, the Director of Nursing (DON) replied, No, Sir. when asked should medications ever be left at the bedside unattended. The DON further replied, Because somebody can take it or it might be missed. after the surveyor asked why medications should not be left at the bedside. A review of the facility-provided policy titled, Administering Medications reviewed and updated in 7/2025 revealed that, 21. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR [Medication Administration Record] may be flagged. After completing the medication pass, the nurse will return to the missed resident to administer the medication. N.J.A.C. 8:29.2(d)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences, specfically by not administering medication for pain within the required timeframes. The deficient practice was identified for 1 of 3 residents (Resident # 8) reviewed for significant medication errors. The deficient practice was evidenced by the following: A review of Resident # 8's Significant Change Minimum Data Set (MDS; an assessment tool) dated 7/20/2025 revealed that he/she had a Brief Interview for Mental Status score of 15/15 indicating no cognitive deficits. The MDS also revealed that Resident # 8 was prescribed medication for pain management. A review of Resident # 8's Physician's Orders located in the Electronic Medical Record (EMR) revealed an order for Lyrica oral capsule 75 milligrams (mg) to be given one capsule, two times daily for Neuropathy (nerve pain). A review of Resident # 8's Care Plan located in the EMR revealed a focus risk for pain related to medical condition/diagnosis initiated on 9/24/2024. The Care Plan focus had an intervention to, Administer medciation as ordered. On 08/19/2025 at 10:34 AM during the initial tour of the facility, the surveyor observed Resident # 8 in bed. At that time, Resident # 8 informed the surveyor that he/she has a pressure ulcer on the buttocks. He/She stated that the wound caused pain. He/She decribed that they felt the pain management was not adequate. A review of the Medication Audit Report located in the EMR revealed the following administration times for the Lyrica 75 mg capsule to be given at 09:00 AM. On 08/03/2025, Lyrica was given at 10:53 [NAME] 08/06/2025, Lyrica was given at 10:38 [NAME] 08/15/2025, Lyrica was given at 10:37 [NAME] 08/18/2025, Lyrica was given at 12:30 PMOn 08/19/2025, Lyrica was given at 11:52 AM A review of the Medication Audit Report located in the EMR revealed the following administration times for the Lyrica 75 mg capsule to be given at 09:00 PM. On 08/06/2025, Lyrica was given at 10:23 PMOn 08/18/2025, Lyrica was given at 10:50 PMOn 08/19/2025, Lyrica was given at 10:44 PM On 08/22/2025 at 10:33 AM during an interview with the surveyor, the Director of Nursing (DON) said medications can be given an hour before and an hour after the scheduled medication time. After reviewing the Lyrica administration times, the DON confirmed that the administration times are considered late. She said the nurse had to call the doctor and check for adverse effects. A review of the facility-provided Administering Medications policy updated 7/2025 revealed, 4. Medications are administered in accordance with prescriber orders, including any required time frame. The policy further revealed that, 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified . N.J.A.C. 8:39-29.2(d)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observations, interview, and review of facility documentation it was determined that the facility failed to follow Pharmacy Consultant recommendations for a resident wearing a weekly medication patch. This deficient practice was identified in 1 of 5 residents reviewed for medications (Resident #14) and was evidenced by the following:On 08/19/2025 at 10:13 AM, during the initial tour of the facility the surveyor observed Resident #14 in the day room sitting in a wheelchair during activities.The surveyor reviewed Resident #14 medical record.A review of the admission Record revealed Resident #14 was admitted to the facility with medical diagnoses which included but were not limited to hemiparesis (muscle weakness or partial paralysis on one side of the body) of the right side, hypertension (high blood pressure), and diabetes (high blood sugar).The surveyor reviewed the quarterly Minimum Data Set (MDS), an assessment tool dated 8/1/25. The resident had a Brief Interview of Mental Status (BIMS) of 3, meaning the resident had severe cognitive impairment.A review of the Physician Order Summary (POS) revealed the resident was prescribed the following medication:Clonodine transdermal patch (medication patch for high blood pressure) weekly, every Saturday for hypertension, rotate sites of administration and remove per schedule. The medication start date was 4/26/25. A review of the residents Individualized Comprehensive Care Plan (ICCP) showed a focus of hypertension. Goals were that the resident would remain free of complications of hypertension. Interventions included but were not limited to administering medications as ordered. Observe for side effects such as orthostatic hypotension and increased heart rate and effectiveness. On 8/21/25 at 10:15 AM, the surveyor reviewed the resident's monthly medication reviews that were completed by the Pharmacy Consultant (PC). Review of the April 2025 review, the PC recommended to check Clonodine patch placement every shift and document accordingly. The surveyor reviewed the April 2025, May 2025, June 2025, July 2025, and August 2025 Medication Administration Report and the Treatment Administration Reports and could not locate documentation of Clonodine Patch Placement.On 8/25/25 at 10:11 AM, the surveyor interviewed the Director of Nursing (DON) regarding placement documentation of medication patch. The DON told the surveyor it was important to check patch placement to ensure it was on the resident to keep the residents blood pressure stable. The DON stated that the nurse failed to do that.On 8/25/25 at 12:00 PM, the surveyor reviewed the policy titled, Pharmacy Services-Role of the Consulting Pharmacist, the policy was dated 10/2024. Number five of the policy revealed that the consultant pharmacist will provide specific activities related to medication regimen review including a documented review of the medication regimen of each resident monthly and providing the facility with written reports and recommendations related to all aspects of medication and pharmaceutical services review. NJAC 8:39-29.3

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure all medications were administered without error of 5% or more. This deficient practice was observed during a medication administration observation on 8/21/2025. The surveyors observed 5 nurses administer medication to 9 residents a with a total of 33 opportunities, and 7 errors were observed which calculated a medication administration error rate of 21.21% during medication administration observation. This deficient practice was identified for 1of 9 residents (Resident #111) that were administered medications by 1 of 5 nurses on the second-floor nursing unit. The deficient practice was evidenced by the following:On 8/21/2025 at 10:02 AM during medication administration observations, the surveyor observed Registered Nurse (RN) dispensing and preparing to administer medication to Resident #111. During the process, the RN first tested Resident #111's blood sugar. The resulting blood sugar was 219mg/dL (milligrams per deciliter), the RN the drew up 4 units of insulin aspart100 unit/milliliter (ml) (rapid-acting insulin used to improve glycemic control in patients with diabetes). The RN was about to draw up another 10 units of insulin aspart 100 unit/ml per resident's order when the surveyor asked to see the order in the computer. Both insulin orders were ordered to be given at 7:30 AM before meals. The RN decided then to hold the insulin until she talked to the doctor because the resident had already eaten breakfast. The RN then proceeded to prepare the rest of Resident # 111's medications as followed:1. Glimepiride 4 milligrams (mg) (a medication that improves blood sugar control) due at 8:00 AM, and to be given with food, was administered at 10:18 AM2. Amlodipine 10 mg (a medication that lowers blood pressure) due at 9:00 AM was administered at 10:18 AM3. Eliquis 2.5 mg (a medication that thins the blood to prevent or treat blood clots) due at 9:00 AM was administered at 10:19 AM.4. Lisinopril 2.5mg (a medication used to treat high blood pressure or heart failure) due at 9:00 AM was administered at 10:28 AM5. Brimonidine tartrate 2mg/ml/timolol 5mg/ml (a medication that reduces the amount of fluid in eye and decreases pressure) due at 9:00 AM was administered at 10:34 AMThe RN administered the medications and when signing them out she said, I am late with all his/her meds. The RN replied, an hour before and an hour after when asked when medications should have be administered. A review of Resident # 111 admission record revealed the resident was admitted to the facility with diagnosis which included but was not limited to Type 2 Diabetes Mellitus (high blood sugar), Hypertension (high blood pressure) and Thrombosis of lower extremity (blood clot). A review of Resident #111's Physician Order Summary (POS) included an order for the following medications: 1. amlodipine 10 mg, give one tablet by mouth in the morning, with a start date of 1/4/2025.2. Eliquis 2.5mg, give one tablet by mouth two times a day for anticoagulant, with a start date of 1/17/20253. Brimonidine tartrate 2mg/ml/timolol 5mg/ml, instill 1 drop in both eyes two times a day for glaucoma, with a start date of 2/2/20254. Glimepiride 4mg, give one tablet by mouth in the morning with food for type 2 diabetes, with a start date of 1/4/20255. Insulin Aspart 100 unit/ml, inject 10 units subcutaneously before meals for diabetes, with a start date of 1/21/20256. Insulin Aspart 100 unit/ml, inject per sliding scale subcutaneously before meals and at bedtime for diabetes, with a start date of 2/1/20257. Lisinopril 2.5mg, give one tablet by mouth once a day for hypertension. During an interview on 8/22/2025 at 10:34 AM with the surveyor, the Director of Nursing (DON) said that medication should be given an hour before to an hour after its scheduled time. The DON also said that insulins ordered before meals should be given on time and prior to the resident eating to prevent spikes in the resident's blood sugar. A review of a facility provided policy updated on 07/2025 titled, Administering Medications revealed, 4. Medications are administered in accordance with the prescriber orders, including any required time frame. 7. Medications are administered with in 1 hour of their prescribed time, unless otherwise specified. and 11. The individual administering the medication checks the label 3 times to verify the right resident, right medication, right dosage, right time. NJAC 8:39- 29.2(d)