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
	65a005	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT REFLECTIONS	1594 ROUTE 88 BRICK, NJ 08724

(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 #: NJ00176449 CENSUS: 45 SAMPLE SIZE: 3 SURVEY DATE: 08/27/2024 - 08/29/2024 The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs, based on this Complaint Survey. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administrator's Responsibilities (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

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This REQUIREMENT is not met as evidenced by:
Complaint #NJ00176449

Based on interview, record review, facility document and policy review, the Executive Director (ED) failed to: 1)ensure the development of appropriate policies and procedures related to diets and following physicians' orders. Specifically, the facility's food service policy indicated residents were responsible to self-regulate their own diets and the facility had no policies in place that addressed medication, treatment, care, services, or following physician orders. 2) In addition, the facility failed to implement its policies to honor residents' rights and follow physician's orders related to a resident's NJ Exec Order 26.4b1, which affected 1 (Resident #1) of 1 resident reviewed for NJ Exec Order 26.4b1 [redacted]. Specifically, staff NJ Exec Order 26.4b1 on Resident #1, who had a NJ Exec Order 26.4b1) order, when the resident NJ Exec Order 26.4b1 and had NJ Exec Order 26.4b1 following a NJ Exec Order 26.4b1

It was determined that the facility's non-compliance with one or more requirements had caused, or was likely to cause, serious injury, harm, impairment, or death to residents.

Findings included:

1. The "Executive Director Summary Job Description," revised 04/01/2011, indicated, under "General Responsibilities," "Direct the day to day functions of the community in accordance with

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current federal, state and local standards, guidelines and regulations that govern assisted living facilities to assure the highest degree of quality care can be provided to our residents at all times." The Executive Director Summary Job Description also indicated, under "Essential Duties," "Assumes the administrative authority, responsibility and accountability of directing the activities and programs of the community."

A facility policy titled, "Nutrition and Menu," revised in October 2017, indicated, "All diets are self-regulated. Dietitian and or Food Service Director will advise a resident on how to adhere to their diet, but it is the residents' responsibility to follow those guidelines."

During an interview on 08/29/2024 at 10:08 AM, the Wellness Director (WD) stated she did not develop or update policies, and all policies were received from the corporate office. The WD stated that she did not expect the residents of the facility to self-regulate their diets, as they would be unable to do so based on their cognitive status. The WD stated she expected all staff to provide care and services according to physicians' orders.

During an interview on 08/29/2024 at 10:12 AM, the Food Service Director (FSD) stated he did not feel that it was appropriate for their resident population to self-regulate their diets due to cognitive concerns. The FSD stated he expected his staff to serve meals according to the physicians' orders and service plans.

During an interview on 08/29/2024 at 10:30 AM, the ED stated there was no policy that addressed that medication, treatments, care, and services should be provided according to physicians'

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orders, but that she expected staff to provide care and services according to the physicians' orders. The ED stated she did not expect residents to self-regulate their diets or identify when they were served a diet that they should not have. The ED stated policies that expected residents to self-regulate their diets were inappropriate for their resident population.

2. On 08/29/2024, the New Jersey Department of Health determined the failed practice represented an immediate threat to residents' health and safety. The facility's Executive Director (ED) was provided a copy of an imminent danger template and informed of the immediacy of the situation involving resident rights, code status. A Removal Plan was requested.

A review of facility policy titled, "Emergency Care," effective 07/01/2021, indicated, "A nurse or a nursing staff member with first aid training will provide emergency first aid as needed to anyone in the community experiencing and accident or incident." The policy revealed, "4. If a situation warrants, the local emergency rescue personnel will be notified for immediate transport to an emergency medical center."

A facility policy titled, "Do Not Resuscitate Orders," revised in February 2009, indicated the section titled "Purpose" included "To ensure requests regarding resuscitation are carried out while in transit from the facility to a physician's office or hospital while in the presence of licensed emergency medical technicians (EMT's) or paramedics where permitted." The policy revealed, "Policies and Responsibilities" included "H. The residents code status will be clearly identified on the residents plan of care." The policy revealed, "Procedure: Staff will perform

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A 310	Continued From page 4 NJ Exec Or and initiate emergency medical services on all residents unless there is a properly executed DNR order on the chart." A facility policy titled, "Resident Rights," effective 06/01/2007, revealed, "Purpose: To assure the provision and protection of resident rights." The policy revealed, "[The facility] will post and distribute a statement of resident rights consistent with the following principles of Assisted Living and additionally the state mandated resident rights document:" to include "Assure each resident the right to make choices with respect to services and lifestyle." A "Resident Information" form revealed the facility admitted Resident #1 on NJ Exec Order 26.4b1 According to the Resident Information document, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1 The Resident Information form revealed the resident had a NJ Exec Order 26.4b1" order. Resident #1's 'NJ Exec Order 26.4b1)," signed by a physician and dated NJ Exec Order 26.4b1 revealed that if the resident were NJ Exec Order 26.4b1 and/or NJ Exec Order 26.4b1, the NJ Exec Order 26 were for NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 " The NJ Exec Order 26. revealed that if the resident NJ Exec Order 26.4b1 and/or was not NJ Exec Order 26.4b1 the wishes were 'NJ Exec Order 26.4b1 ." The NJ Exec Order 26. was signed by the resident's NJ Exec Order 26.4b1 Resident #1's "Physician Order Sheet," for active orders as of NJ Exec Order 26.4b1 indicated the resident had a NJ Exec Or NJ Exec Or NJ Exec Order 2 Resident #1's "Observations for [Resident #1]"	A 310		

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note dated NJ Exec Order 26.4b1 at 8:45 AM revealed that the Wellness Director (WD) was called to the "NJ Exec Ord dining room and observed the resident NJ Exec Order 26.4b The note revealed that the primary nurse NJ Exec Order 26.4b1." Per the note, "Staff NJ Exec O NJ Exec Ord to NJ Exec Order 26.4b1s between the NJ Exec Order 26.4b1 with the NJ Exec Order 26.4b1." The note indicated that the NJ Exec Order 26.4b1 was checked, and staff were NJ Exec Order 26.4b1 or get the resident to NJ Exec Order 2 Per the note, NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 The note indicated that NJ Exec was called to assist. Per the note, the resident was NJ Exec Order 26.4b1 at 8:25 AM on NJ Exec Order 26.4b1

During an interview on 08/27/2024 at 10:31 AM, Licensed Practical Nurse (LPN) #1 stated that on NJ Exec Order 26.4b1 at about 8:15 AM, a NJ Exec Order 26.4b1 approached her, informing her that there was an NJ Exec Order 26.4b1 on the other side of the building, in the "NJ Exec Or side." LPN #1 stated she was passing medication on the "NJ Exec Or side" of the facility and went to the NJ Exec O common area. She stated that on arrival, she observed Resident #1 NJ Exec Order 26.4b1, NJ Exec Order 26.4b1. She stated that the resident's NJ Exec O , and the two nurses present, the WD and LPN #2, informed her that the resident NJ Exec Order 26.4b1. Per LPN #1, the nurses informed her that they had already NJ Exec Order 26.4b1, the NJ Exec Order 26.4b1 was NJ Exec Order 26 to the resident, and NJ Exec Or was being NJ Exec Order 26.4b1 She stated that soon after, the NJ Exec Order and NJ Exec Order 26.4b1 arrived, taking over NJ Exec Orde LPN #1 stated she presented the NJ Exec Order 26.4b1 with the resident's NJ Exec Order 26.4b1, and shortly after presenting the NJ Exec Orde the NJ Exec Order 26.4b1 stopped NJ Exec Orde and the resident was NJ Exec Order 26.4b1.

During an interview on 08/27/2024 at 2:59 PM, LPN #2 stated that on NJ Exec Order 26.4b1 she was near

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the NJ Exec Or dining room passing medications. She stated that she observed Server #2 place a plate in front of Resident #1 and heard Server #2 telling the resident NJ Exec Order 26.4b1 . She stated that she told Server #1 that she was going to finish giving medication to a resident and would then come over to help. Per LPN #2, when she arrived at Resident #1's table, she observed the resident with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . She stated that she instructed the resident to NJ Exec Order 26 and the resident NJ Exec Order 26.4b She stated she tried to do a NJ Exec Order 26.4b1 and the resident NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 rom her. She stated that she followed the resident, and the resident then NJ Exec Order 26.4b1 to the table NJ Exec Order 26.4b she NJ Exec Order 26.4b1 the table. LPN #2 stated that she again prompted the resident to NJ Exec Order 26.4b1 , stating that the resident NJ Exec Order 26.4b1 . She stated that Resident #1 then appeared to start NJ Exec Order 26.4b at which time she started NJ Exec Order 2 the resident's NJ Exec Orde She stated that the resident got up from the table again, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 , at which time she thought the resident may be NJ Exec Order 26.4b LPN #2 stated she NJ Exec Order 26.4b1 NJ Exec Order), then the resident NJ Exec Order 26.4b1 . LPN #2 stated that she NJ Exec Orde the resident NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 " with the NJ Exec Order 26.4b1 She stated she then NJ Exec Orde the resident on their NJ Exec Orde no longer NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 "some NJ Exec Order 26.4b1 ," NJ Exec Order 26.4b1 to "try to NJ Exec Order 26.4b1 ." LPN #2 stated she recalled the resident's NJ Exec Order 26.4b1 , at which time she

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yelled for help and asked someone (did not recall who) to get the WD. She stated she continued to alternate between NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 until the WD arrived. She stated that the WD arrived with the [redacted] initiated a call to [redacted] and she (LPN #2) started [redacted] LPN #2 stated that she was unaware that Resident #1 had a [redacted] and [redacted] was continued until NJ Exec Order 26.4b1 arrived. LPN #2 stated she observed the NJ Exec Order 26.4b1 perform a [redacted] and [redacted] a NJ Exec Order 26.4b1 from the resident's [redacted] She stated that NJ Exec Order 26.4b1 were then notified by another staff member that Resident #1 had a [redacted] order. She stated that [redacted] was stopped, and the resident was NJ Exec Order 26.4b1.

During an interview on 08/27/2024 at 4:48 PM, the WD stated that on NJ Exec Order 26.4b1 at about 8:15 AM, staff called her to the [redacted] dining area. She stated that, upon arrival, she observed Resident #1 NJ Exec Order 26.4b1, and LPN #2 was NJ Exec Order 26.4b1 to "NJ Exec Order 26.4b1." The WD stated that [redacted] should have been initiated immediately once the resident became NJ Exec Order 26.4b1 She stated she was unaware that Resident #1 had a NJ Exec Order 26.4b1, and instructed staff to initiate [redacted] at that time and to call [redacted] The WD stated that LPN #2 should have called for help and [redacted] as soon as she formed the suspicion that the resident was [redacted] She stated that when NJ Exec Order 26.4b1 arrived, they were presented with the NJ Exec Order 26.4b1, [redacted] was stopped, and the resident was NJ Exec Order 26.4b1 at 08:25 AM.

On 08/29/2024 at 9:12 AM, the ED was provided with the imminent danger template. The ED

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A 310	Continued From page 8 signed the template, retained a copy, and returned the original to the surveyor. On 8/30/24, the facility submitted a Removal Plan that indicated that developed a new dietart procedures and staff were inserviced and re-educated on dietary issues and new dietary procedures. The Removal Plan also included staff inserviced on DNR, Resident Rights, and Emergency Care facility procedures.	A 310		

BRANDYWINE
REFLECTIONS
MEMORY CARE

Plan of Correction
Brandywine Living at Reflections
Reportable Event Visit 8/27/24-8/29/24
Submitted by: Melissa Hingher, Executive Director

A310 8:36-3.4(a)(1) Administration

1. Unable to correct; resident affected by the deficient practice is [redacted]
2. All residents have the potential to be affected by the deficient practice.
3. To ensure this deficient practice will not recur, the following measures will be put in place:
   a. A new Diet Orders policy, specific for memory care residents, was implemented on August 30, 2024. All dining and nursing department staff were trained on these new policies on August 30, 2024. Any dining or nursing staff unable to attend the August 30, 2024, training session were trained at the start of their next shift, prior to taking the floor.
   b. A list of residents with their specific diet has been posted in the back hallway at the entrance to both dining rooms.
   c. A list of residents with DNR orders in place have been posted at both nursing carts in addition to at the AED machine.
4. To ensure this deficient practice does not recur, new order sheets have been implemented which are date specific. These order sheets list the resident's name and their diet, which is reviewed every morning and only used for that specific date. Nursing and Dietary staff will also be in-serviced again by February 28, 2025, 6 months after the initial in-service.

BRANDYWINE
REFLECTIONS
MEMORY CARE

A 531 8:36-5.6 (c) General Requirements

1. Unable to correct; resident affected by the deficient practice is NJ Exec Order 26.4b1
2. All residents have the potential to be affected by the deficient practice.
3. To ensure this deficient practice will not recur, the following measures will be put in place:
   a. A new policy on Dietary Needs Supervision was implemented to define 2 levels of supervision providing in the dining room, Supervision/under supervision or One to One.
   b. The LPN was terminated and no longer works for Brandywine.
   c. The Director of Clinical Services reviewed the current resident charts and found no residents with orders for one-to-one supervision.
   d. Staff were in-serviced regarding Choking procedures on 8/20/24.
4. To ensure this deficient practice is being corrected and does not recur, the Executive Director or Director of Clinical Services will notify the guardian or attorney-in-fact if the resident's physician or therapist orders one-to-one supervision to discuss how that need will be met, and the resident's care plan will be adjusted accordingly. Choking procedures will be reviewed annually.

A 709 8:36-7.2(d)(1-18) Resident Assessments and Care Plans

1. Unable to correct; resident affected by the deficient practice is NJ Exec Order 26.4b1
2. All residents have the potential to be affected by the deficient practice.
3. To ensure this deficient practice does not recur, a policy was implemented that states the registered professional nurse will update resident assessments and care plans every 180 days and/or with a change in condition. Policy also implemented to notify the registered professional nurse for any change in condition requiring medical attention and/or intervention. All staff are also offered CPR training.
4. To ensure this deficient practice is corrected and does not recur, the Director of Clinical Services will be the primary individual responsible for inputting code status orders or revocations within a resident's chart and

care plan, and the Director of Clinical Services updates the written list whenever there are changes in residency or a resident's code status within the same day. If the Director of Clinical Services is not available to personally input a code order, the Director will be informed of this change by the nurse who inputs the orders on the 24 hour report, and the Director will make the changes on the DNR lists. This list is posted at the AED machine and at both medication carts.

A 763 8:36-7.4(b) Resident Assessments and Care Plans

1. Unable to correct; resident affected by the deficient practice is NJ Exec Order 26.4b1
2. All residents have the potential to be affected by the deficient practice.
3. To ensure this deficient practice does not recur, memory care specific policies were implemented regarding Diet Supervision Needs and Diet orders.
4. To ensure this deficient practice is corrected and does not recur, policies will be reviewed quarterly by the QI team. Policies found not to meet the needs of the community's population will be rewritten and implemented.

A 779 8:36-7.5(c) Resident Assessments and Care Plans

1. Unable to correct; resident affected by the deficient practice is NJ Exec Order 26.4b1
2. All residents have the potential to be affected by the deficient practice.
3. To ensure this deficient practice will not recur, all staff completed an in-service regarding Recognizing Change in Condition in December 2024.
4. To ensure this deficient practice is corrected, the in-service will be repeated 3 months after the original in-service, in March 2025.

BRANDYWINE
REFLECTIONS
MEMORY CARE

A 903 8:36-10.5(c) (5) Dining Services

1. Unable to correct; resident affected by the deficient practice is [redacted]
2. All residents have the potential to be affected by the deficient practice.
3. To ensure this deficient practice will not recur, a policy was implemented stating all residents will have their dietary needs evaluated and this diet will be prepared and served according to the order. Staff were in-serviced on this policy on 8/30/24.
4. To ensure this deficient practice is corrected, diet orders will be reviewed quarterly by the QI team. Diet orders will be posted for all staff to access, with a picture of the resident, upon admission, and following any change in condition/updated dietary order. The dietician will perform random quarterly audits of resident diets and chart orders. The community will maintain updated dietary manuals annually. Team members providing resident care and those in dining services are educated on dietary selections and dining policies, prior to assisting residents with meal services.