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	55A002	A. BUILDING: _____ B. WING _____	C 05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT GOVERNOR'S CROSSING	49 LASATTA AVENUE ENGLISHTOWN, NJ 07726

(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 #: NJ00143849, NJ00142722, NJ00144135 CENSUS: 64 SAMPLE SIZE: 11 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 361	8:36-4.1(a)(4) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 4. The right to be treated with respect, courtesy, consideration and dignity; This REQUIREMENT is not met as evidenced	A 361		

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A 361	Continued From page 1 by: Complaint #: NJ 00143849 Based on interview and record review it was determined that the facility failed to ensure that the rights of all residents were observed when 2 of 11 residents reviewed for [redacted] were not treated with [redacted] and [redacted] at all times, Resident #4 and Resident #6. This deficient practice was evidenced by the following: On 4/7/21 at 9:45 a.m., during the entrance conference of the survey, Surveyor #1 interviewed the Executive Director (ED) and asked if there were any incidents of staff to resident [redacted] that occurred at the facility during the [redacted]. The ED stated that there was a [redacted] that occurred, but that she would not call it [redacted] The ED stated that the incident was reported to her by another resident, who overheard the conversation, and that the employee was [redacted]. The ED then provided the surveyor with a copy of a statement of the incident which, was written by the ED. According to the written statement, [redacted] occurred at the facility on [redacted] with Resident #4 and a Licensed Practical Nurse (LPN), LPN #1. 1. On 4/7/21 at 11:50 a.m., the surveyor reviewed Resident #4's medical record which revealed that the resident was admitted to the facility [redacted] with diagnoses which [redacted] According to surveyor review, the "Admission Assessment/Significant Change Assessment," dated [redacted] indicated that the [redacted] The resident was not available for interview at the time of the survey.	A 361		

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A 361	Continued From page 2 The surveyor reviewed the statement provided by the ED and observed documented that on NJ Exec Order 2[redacted], Resident #4 stated that at approximately 3:30 p.m., the resident asked a Certified Nursing Assistant (CNA) to assist with getting back into bed prior to dinner. According to the written statement, the resident NJ ex order 26.4b1 [redacted] since 9:15 a.m., NJ ex order 26.4b1 [redacted] Further, the ED documented that LPN #1 was brought to the resident's room to assist with the NJ Exec Order 26.4 and at that time the LPN #1 stated to Resident #4, "NJ ex order 26.4b1 [redacted] " The ED documented that Resident #4 stated that LPN #1's NJ Exec O[redacted] made him/her [Resident] NJ ex order 26.4b1 [redacted] Finally, the ED documented that the incident was brought to her attention by another resident, who stated that he/she was appalled when he/she [the other Resident] overheard LPN #1 also say to Resident #4, NJ ex order 26.4b1 [redacted] 2. On 4/7/21 at 1:30 p.m., the surveyor interviewed the ED and the current Director of Nursing (DON) regarding a Home Health Aide (HHA) after the surveyor reviewed the employee's personnel file. The surveyor inquired if the HHA was involved in an incident with any resident. The ED stated that there was an incident which occurred last year NJ ex order 26 [redacted] that involved the HHA. The ED stated that the former DON investigated and addressed the NJ ex order 26.4b1 The ED then provided the surveyor with a copy of a document, written by the former DON, titled,	A 361		

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A 361	Continued From page 3 "General." The surveyor reviewed the former DON's statement dated [redacted] at 11:19 a.m., which indicated that the former DON spoke with the HHA regarding an incident in which the HHA entered a residents' room when the room was [redacted] Resident #6, which [redacted] Resident #6. When the resident asked what the item that the [redacted], the HHA stated, "[redacted]," and according to the former DON's documentation, the [redacted]. On 4/8/21 at 10:05 a.m., Surveyor #1 reviewed Resident #6's medical record and according to the, "Resident Information" document, the resident was admitted to the facility in [redacted]. On 4/8/21 at 10:55 a.m., Surveyor #1 observed Resident #6 [redacted]. The surveyor then interviewed Resident #6 and asked about the care that he/she received at the facility. Resident #6 [redacted]. The surveyor asked Resident #6 if he/she recalled an [redacted]. Resident #6 stated that [redacted]. On 4/8/21 at 11:30 a.m., the surveyor reviewed the facility's policy titled, "Resident Rights," dated June 1, 2007, which indicated, "Treat each	A 361		

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A 361	Continued From page 4 resident with respect, courtesy, consideration and dignity." Additionally, "Assure each resident the right to make choices with respect to services and lifestyle."	A 361		
A 565	8:36-5.10(a)(3) General Requirements (a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 (609) 392-2020 if after business hours, followed within 72 hours by written confirmation, of the following: 3. Any suspected cases of resident abuse or exploitation which have been reported to the State Long-Term Care Ombudsman. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00143849 Based on interview and record review it was determined that the facility failed to notify the Department of Health (DOH) of NJ Exec Order 26.4b1 [redacted] NJ ex order 26.4b1 on NJ ex order 26.4b1 at the facility for 2 of 11 residents reviewed, Resident #4 and Resident #6. This deficient practice was evidenced by the following: 1. On 4/7/21 at 9:45 a.m., during the entrance conference of the survey, Surveyor #1	A 565		

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A 565	Continued From page 5	A 565		

interviewed the Executive Director (ED) and asked if there were any incidents of NJ Exec Order [redacted] that occurred at the facility during the NJ Exec Order 26.4b1. The ED stated that there was a NJ Exec Order 26.4b1 that occurred, but that she would not call it NJ Exec Order [redacted] The ED stated that the incident was reported to her by another resident, who overheard the conversation, and that the employee was NJ Exec Order 26.4b1 The ED then provided the surveyor with a copy of a statement of the incident which, was written by the ED. According to the written statement, NJ Exec Order [redacted] NJ ex order 26.4b1 occurred at the facility on NJ ex order 26.4b1 with Resident #4 and a Licensed Practical Nurse (LPN), LPN #1.

On 4/7/21 at 11:50 a.m., the surveyor reviewed Resident #4's medical record, which indicated that the resident was admitted to the facility in NJ ex order 26.4b1 with diagnoses which included NJ ex order 26.4b1. According to the, "Admission Assessment/Significant Change Assessment," dated NJ ex order 26.4b, Resident #4 was alert, and NJ ex order 26.4b1 [redacted] The resident was not available for interview at the time of this survey, however, the NJ Exec Order 26.4b1 was that a staff member, LPN #1, stated to Resident #4, NJ Exec Order 26.4b1 [redacted] " when the NJ ex order 26.4b1 [redacted]

2. On 4/7/21 at 1:30 p.m., Surveyor #1 interviewed the ED and the current Director of Nursing (DON) regarding a Home Health Aide (HHA) after the surveyor reviewed the employee's personnel file. The surveyor inquired NJ ex order 26.4b1 [redacted]. The ED stated that NJ ex order 26.4b1 [redacted] and it involved

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A 565	Continued From page 6 Resident #6. The ED stated that the former DON investigated and addressed the NJ ex order 26.4b1 [redacted] The ED then provided the surveyor with a document titled, "General," which the ED identified was a statement written by the former DON, which indicated that Resident #6 NJ ex order 26.4b1 [redacted]. The statement went on to indicate that the NJ ex order 26.4b1 [redacted] and NJ ex order 26.4b1 [redacted] On 4/8/21 at 10:55 a.m., the surveyor observed Resident #6 as he/she NJ ex order 26.4b1 [redacted] During interview, Resident #6 NJ ex order 26.4b1 [redacted]. The surveyor asked the resident about the care that he/she received at the facility and the resident stated that the care was good and that there were no concerns. The surveyor asked Resident #6 if he/she recalled an NJ ex order 26.4b1 [redacted] mentioned above. Resident #6 stated that he/she NJ ex order 26.4b1 [redacted] During continued interview, the ED confirmed that the above NJ Exec Order 26.4b1 [redacted] of NJ ex order 26.4b1, which involved Resident #4 and Resident #6, NJ ex order 26.4b1 [redacted]. Refer to 8:36-4.1(a)(4)	A 565		
A 935	8:36-11.4(b) Pharmaceutical Services (b) All medications shall be administered by qualified personnel in accordance with prescriber	A 935		

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A 935	Continued From page 7 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 #: NJ00143849 Based on observation, interview, and record review, it was determined that the facility failed to ensure that medications were administered in accordance with prescribers' orders and facility policy and procedures for 1 of 11 residents reviewed for medication administration, Resident #9. This deficient practice was evidenced by the following: On 4/8/21 at 8:45 a.m., Surveyor #1 and Surveyor #2 observed a Registered Nurse (RN) in the Health and Wellness Office (HWO), on the third floor of the facility, as she stood in front of the medication cart. The surveyors informed the RN that they were going to observe her, the RN, as she administered medications to residents. The RN stated that NJ ex order 26.4b1 , that NJ ex order 26.4b1 , but that she was called in to help due to a staff member call out. On 4/8/21 at 8:55 a.m., Surveyor #1 and Surveyor #2, while waiting for the RN to start the medication pass, observed Resident #9 and	A 935		

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A 935	Continued From page 8	A 935		

Resident #3 seated across from each other on benches located outside of the HWO.

On 4/8/21 at 9:00 a.m., the surveyors observed the RN review the Electronic Medication Administration Record (eMAR) for Resident #9's [redacted] and the RN [redacted] from the medication cart and stated that she was going to give medications to Resident #9. The RN then reviewed the eMAR a second time, after looking at the [redacted], and stated that she was going to give medication to Resident #3, instead of Resident #9 as she originally stated. Surveyor #1 and Surveyor #2 reviewed the label on the [redacted] that read the name of Resident #3, and the name of the medication, which read, [redacted] Surveyor #1 then handed the [redacted] back to the RN and viewed the eMAR. The RN then performed hand hygiene and donned gloves. While, Surveyor #1 reviewed Resident #3's eMAR, the RN walked away from the HWO to administer the medication. Surveyor #2, who was near the HWO door, observed the RN walk away from the office and followed the RN to observe the RN during the medication pass. Surveyor #2 then observed the RN instill [redacted] of Resident #9.

Surveyor #2 interviewed the RN and asked how she knew Resident #9's identity. The RN stated that she had given Resident #9 medication earlier. Surveyor #2 also observed that the RN did not identify Resident #9 by asking Resident's name prior to administering the [redacted]. At that time, Surveyor #1 exited out of the HWO and observed the RN as she walked away from Resident #9 asked the RN who did she administer medication to. The RN then pointed at Resident #9, but stated that she administered

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medication to Resident #3, both residents were seated on benches across from each other. Surveyor #1 then stated to the RN that she had not given Resident #3 medication, but rather that she had given medication to Resident #9. Surveyor #1 knew the identity of Resident #3 from an interview the surveyor conducted on [redacted], and from review of the eMAR.

On 4/8/21 at 10:00 a.m., Surveyor #1 and Surveyor #2 informed the Executive Director and the DON that there was a NJ ex order 26.4b1 [redacted] The DON stated that she would handle and discuss the error with the RN.

On 4/8/21 at 11:15 a.m., Surveyor #1 and Surveyor #2 reviewed Resident #9's medical record, which revealed that Resident #9 was admitted to the facility in NJ ex order 26.4b1 with a diagnosis which included NJ ex order 26.4b1. Surveyor review of the Physician Order Sheet revealed that Resident #9 NJ ex order 26.4b1 [redacted] which was timed to be given at 9:00 a.m.

Further surveyor review of Resident #9's medical record revealed that according to the MAR dated NJ Exec Order 26.4b1, the RN signed that she administered the ordered NJ ex order 26.4b1 to Resident #9, however, as documented above, she administered Resident #3's NJ ex order 26.4b1 to Resident #9 NJ ex order 26.4b

On 4/8/21 at 11:35 a.m., Surveyor #2 reviewed Resident #3's medical record and observed documented that Resident #3 NJ ex order 26.4b1 [redacted]

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A 935	Continued From page 10 On 4/8/21 at 12:00 p.m., post medication administration, Surveyor #1 and Surveyor #2, interviewed the RN regarding the medication error of giving Resident #9 Resident #3's [NJ ex ord] [redacted]. The RN stated that she was not familiar with the residents and admitted that she gave the [NJ Exec Order 26.4b1] to the wrong resident. On 4/8/21 at 12:15 p.m. Surveyor #2 reviewed the facility policy titled, "Medication Error Reporting, dated 9/02 and revised on 8/09," which revealed, "The center will take a proactive approach by focusing on Quality Improvement activities involving medication administration... use of two identifiers prior to medication administration..."	A 935		
A 961	8:36-11.5(e) Pharmaceutical Services (e) The registered professional nurse shall report medication errors and adverse drug reactions immediately to the prescriber, to the provider pharmacist and/or consultant pharmacist, and shall document the incident in the resident's record. This REQUIREMENT is not met as evidenced by: Complaint # NJ00143849 Based on interview and record review it was determined that the facility failed to follow and implement its policy and procedures on medication error reporting and documentation for 1 of 11 residents reviewed for medication administration, Resident #9. This deficient practice was evidenced by the following:	A 961		

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A 961	Continued From page 11 On 4/8/21 at 9:00 a.m., Surveyor #1 and Surveyor #2 observed a medication administration error at the facility when a Registered Nurse (RN) administered Resident #3's NJ ex order 26.4b1 [redacted] On 5/20/21 at 9:00 a.m., Surveyor #2 and Surveyor #3 conducted an interview with the Director of Nursing (DON) regarding the facility protocol for medication errors. The DON stated that the process was that a medication error report would be completed, staff would be educated, and the pharmacy would be notified. Surveyor #2 and Surveyor #3 asked the DON to explain what procedure was followed for the medication error which occurred at the facility, which was instilled in the eyes of Resident #9, in error, on 4/8/21. The DON stated that Resident #3's NJ ex order 26.4b1 was disposed of and a new bottle was ordered from the pharmacy. The DON explained that she did not know if Resident #9 or Resident #9's Physician was made aware that Resident #9 received Resident #3's NJ ex order 26.4b1. The DON further stated that the RN, that performed the medication NJ ex order 26.4b1, NJ ex order 26.4b1 [redacted] The DON then stated that any additional information the surveyors needed regarding the incident, they would have to get it from the RN. On 5/20/21 at 10:30 a.m., in the presence of the DON, Surveyor #2 and Surveyor #3 conducted a telephone interview with the RN that performed the NJ ex order 26.4b1 on NJ ex order 26. The RN stated that Resident #9 was notified that he/she NJ ex order 26.4b1 and that Resident #3's NJ ex order 26.4b1. The RN further stated that the pharmacy was made	A 961		

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A 961	Continued From page 12	A 961		

aware and she, the RN, was not sure if a medication error report was filled out or if there was any written documentation. Surveyor #3 asked the RN if Resident #9's Physician was notified that he/she, Resident #9, NJ ex order 26.4b1 [redacted] The RN stated that she was not sure.

On 5/20/21 at 11:20 a.m. Surveyor #2 and Surveyor #3 reviewed the "Observation Notes in Resident #9's medical record and observed that there was no documentation on [redacted] that Resident #9 NJ ex order 26.4b1 [redacted] nor did the NJ ex order 26.4b1 [redacted] Resident #9 NJ ex order 26.4b1 [redacted]. The surveyors did however observe that a Licensed Practical Nurse (LPN), LPN #2 documented that Resident #9 NJ ex order 26.4b1 [redacted] and according to the [redacted] form dated [redacted], there were no changes.

On 5/20/21 at 11:40 a.m., Surveyor #2 reviewed the facility policy and procedure, titled "Medication Error Reporting, dated 9/02 and revised on 8/09, which indicated "The physician will be notified of incident, assessment of resident and immediate actions taken immediately." Additionally, "The RN must document the incident and conduct immediate investigation of the incident." "Medication Discrepancy Report will be completed by the nurse responsible for medication discrepancy or by the nurse who discovers the discrepancy in conjunction with the RN and will include: Analysis of error, Description of error, Outcome to resident, Corrective Actions, Measures taken to prevent reoccurrence, Physicians response, Signatures: nurse, Pharmacist, DON..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55A002	A. BUILDING: _____ B. WING _____	C 05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT GOVERNOR'S CROSSING	49 LASATTA AVENUE ENGLISHTOWN, NJ 07726

(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 961	Continued From page 13 Refer to deficiency A-0935- 8:36-11.4(b)	A 961		

BRANDYWINE LIVING
at Governor's Crossing
Life is Beautiful

Plan of Correction for Complaint # 143849

A361

Resident Rights

1. How the corrective action will be accomplished for residents found to have been affected by the deficient practice:
   Resident #4 NJ ex order 26.4b1
   An investigation was done and it was concluded that this resident was having their rights denied, and the Licensed Practical Nurse that was responsible for this was [redacted]

   The investigation was completed and NJ ex order 26.4b1 [redacted]

   Resident #6 let the Director of Wellness at the time know of concern that they felt NJ Exec Order 26.4b1 with the way the team member told them how to NJ Exec Order 26.4b1 on their NJ Exec Order 26.4b1 [redacted]
   Care manager was spoken to and a general note was made in their chart about the incident. This care manager was removed from taking care of this resident as per the Director of Wellness at the time.

2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.*

   All residents have the potential to be affected by this deficient practice.

3. *What measures will be put into place or systematic changes made to ensure that the deficient practice would not recur.*
   All team members have been notified to report any suspect of a residents rights being infringed upon.
   Open door policy with the Executive Director or designee for all residents to freely discuss, in private, any grievances or concerns they may have beyond the monthly Resident Council meetings pertaining to their resident rights.

49 LASATTA AVENUE ENGLISHTOWN new jersey 07726
phone 732.786.1000 fax 732.786.0689
WWW.BRANDYCARE.COM

Residents have a copy of their Residents Rights in their move in packet and it is clearly posted in the building upon entry and on additional floors.

All team members are instructed to bring any concerns to the Executive Director or designee

Completed on 4/17/21 and ongoing with new hires.

The entire team was re-educated on the following topics as in-services facility wide.

- Residents Rights
- All about Respect

This was conducted between April 12-April 17-for a completion date of April 17, 2021

4. *How will the facility monitor its corrective actions to ensure that this deficient practice is being corrected and will not occur again.*
   - The Executive Director or designee will hold ongoing small impromptu round tables with the residents monthly.
   - The Executive Director or designee will be responsible for maintaining an open line of communication with residents and team members to ensure all feel they are being heard and are having their rights respected.
   - Completed on 4/17/21.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
55A002 Y1	A. Building B. Wing Y2	6/25/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT GOVERNOR'S CROSSING	49 LASATTA AVENUE ENGLISHTOWN, NJ 07726

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	A0361	Correction	ID Prefix	A0565	Correction	ID Prefix	A0935	Correction
Reg. #	8:36-4.1(a)(4)	Completed	Reg. #	8:36-5.10(a)(3)	Completed	Reg. #	8:36-11.4(b)	Completed
LSC		05/28/2021	LSC		05/28/2021	LSC		05/28/2021
ID Prefix	A0961	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	8:36-11.5(e)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		05/28/2021	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	
5/20/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO