PRINTED: 08/29/2024 FORM APPROVED

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
			A. BOILDING.								
		55A112	B. WING		01/29/2024						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
BRANDYWINE LIVING AT WALL 2021 HIGHWAY 35 WALL, NJ 07719											
(X4) ID											
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)							
A 000	Initial Comments		A 000								
	Initial Comments: Census: 73										
	Sample: 3										
A1271	conducted by the Sta The facility was found with the New Jersey / infection control regul Licensure of Assisted Comprehensive Pers Assisted Living Progr Disease Control and recommended practic COVID-19.	Living Residences, onal Care Homes and ams and Centers for Prevention (CDC)	A1271								
	(a) The facility shall d infection prevention a	evelop and implement an ind control program.									
	by: Based on observation review, it was determ implement its infectio program in accordance Disease Control (CDC and the facility's "CO' Plan" by failing to ensumember and the Assi wore face masks app	ce with the Communicable C) and Prevention guidelines VID 19 Outbreak Response sure one dietary staff stant Director of Nursing									

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

PRINTED: 08/29/2024 FORM APPROVED

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		55A112	B. WING		01/29/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE	•	
TVAIVIL OF T	NOVIDER OR GOLT EIER	2021 HIG	, ,	KIE, ZII GOBE		
BRANDY	WINE LIVING AT WALL	WALL, N				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE	
A1271	The surveyor visited to during the 1/21/2024 and continued to the surveyor #1 observed her surgical mask under a while conversing Surveyor's #1 and #2 Director of Nursing or without a mask. Surveyor #2 reviewed procedures titled, "Us Communities related revealed, "When SAR Transmission levels a (covering your nose a keep your respiratory recommended for eves setting when they are	d staff of the facility and was g: the facility on 1/29/2024 outbreak that started on used through the survey visit. It our of the facility's kitchen, a dining assistant wearing ther her nose in the dining with residents. It our of the memory unit, observed the Assistant in the unit in the hallway If the facilities policies and the of source control in the COVID-19" which its-CoV-2 Community re high, source control ind mouth with a mask to droplets out of the air) is	A1271			