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 07/28/2021

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 #: NJ 00146777 CENSUS: 45 SAMPLE SIZE: 4 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, based on this complaint visit. 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) Administration (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		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review it was determined that the facility failed to implement and enforce its policy and procedure titled, "Storage of hazardous chemicals," to ensure the health and safety of 3 of 4 residents reviewed for safety, Resident #'s 1, 3, and 4, which placed the residents at risk for [NJ Exec Ord] or [NJ Exec Ord]. This deficient practice was evidenced by the following:

Review of Facility Reportable Event Record/Report (FRE) form received by the Department of Health (DOH) on [NJ Ex Order 26.4] revealed that on [NJ Ex Order 26.4], a care manager found a resident, Resident #1, NJ Ex Order 26.4(b)(1) [redacted] on [NJ Ex Order 26.4(b)(1)] while walking in one of the facility unit, [NJ Ex Ord] hall. The report indicated that the facility staff were unsure if the resident [NJ Ex Order 26.4(b] the NJ Ex Order 26.4(b)(1).

During the survey on 7/28/21 at 11:00 a.m., Surveyor #1, in the presence of the facility's Director of Maintenance, toured and conducted an inspection of the different areas, units and hallways of the facility and observed some cabinets were locked and with the ones that were unlocked did not have chemicals or harmful products inside.

At 11:30 a.m., Surveyor #1 and Surveyor #2 reviewed the facility policy and procedure titled, "Storage of hazardous chemicals" which listed under "Policy and Responsibilities: 1. No

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hazardous materials defined as a label which states may be hazardous to children may be stored in any resident care area or area that is accessible to any resident in any Reflections unit- this may include mouthwash, shampoos, lotions if the label has a precautionary statement."

At 11:45 a.m., Surveyor #2 conducted an inspection of resident apartment #'s [redacted] and [redacted] and the Wellness office with the Executive Director (ED), and found the following items in the following locations:

1. Resident #3 (Room #[redacted]): [redacted] of [redacted] were found inside the cabinet that was unlocked, next to the refrigerator. The ED stated that the cabinet should have been locked and that [redacted] were kept locked in the laundry room.

2. Resident #4 (Room [redacted]): In the unlocked cabinet two bottles of [redacted] and a bottle of [redacted] were found. The ED stated that the cabinet should have been locked.

3. At 12:10 p.m., during continued tour with the ED, Surveyor #2 observed that the nursing station/office door was left unlocked with no staff inside the office. The Wellness Director (WD) immediately followed Surveyor #2 and the ED and went inside the Wellness office. Inside the office, the surveyor observed a shelf with the following items: a [redacted] of [redacted], lotion, container of body wash and a container labeled "[redacted]," all were visible upon entering the office. The surveyor interviewed the WD regarding the "[redacted]" container on the shelf, she stated that they use this [redacted] for medication destruction. She also stated that they will keep it

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locked and not leave it on the shelf. The WD took the NJ Ex Order 26.4(b)(1) container and placed it inside the bottom cabinet and closed the cabinet door. The WD stated that they may have to install a lock in that cabinet and to ensure that staff to keep the nursing office door locked.

At 1:00 p.m., in the conference room, the surveyors interviewed CNA #1, who stated that she was made aware of Resident #1's incident on NJ Ex Order 26.4, when the resident was found with a NJ Ex Order 26.4(b)(1) in his/her NJ Ex Order She stated that she was not there at the day of the incident. CNA #1 also mentioned that Resident #1 NJ Ex Order 26.4(b)(1)." Surveyors asked CNA #1 to explain the procedure for handling personal hygiene and laundry products. CNA #1 stated that staff would put items inside the resident's locked cabinet. She also stated that she had been having problems with the residents' room cabinets not locking very well and the number buttons were so tiny on the code pad locks.

At 2:00 p.m., during a telephone interview with CNA #2, the surveyors asked CNA #2 to explain the policy and procedure for storage of chemicals and hygiene products. CNA #2 stated that all chemicals and hygiene products are locked away. She also stated that all resident lotions and shampoos were locked in cabinets. In addition, she stated that she recently received an in-service on keeping all chemicals in locked storage.

At 3:10 p.m., Surveyor #1 and Surveyor #2, in the presence of the Director of Maintenance and another maintenance staff, inspected and re-inspected Resident #'s 3 (NJ Ex) and 4 (NJ Ex C) apartments. Upon re-inspection, both apartments' cabinets remained unlocked and the

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same items previously viewed were still inside the cabinets that were unlocked. The maintenance staff was observed locking the cabinets.

Additionally, Resident #1's apartment was inspected at 3:20 p.m. Both surveyors observed that the cabinet inside the resident's apartment had a padlock that was left in an unlocked position and inside the cabinet were bottles of [redacted], [redacted], and [redacted]. The Maintenance Director instructed the maintenance staff to lock the cabinet, using the combination pad lock, and he did.

Review of Resident #'s 1, 3, and 4 medical records revealed that the residents were assessed with [redacted] to [redacted].

At 4:10 p.m., during an interview with the licensed practical nurse (LPN), she stated that on [redacted], a care manager approached her and the ED, to notify them that Resident #1 was found in [redacted] hall near the dining/kitchen area, with a [redacted] in his/her [redacted] She stated that they could not determine where the resident got the [redacted]. The LPN stated that she called [redacted] and was instructed to [redacted] the resident for [redacted]. She stated that Resident #1 was [redacted] as instructed, including [redacted] resident's vital signs which she said were [redacted] to the resident's [redacted] and to have the resident [redacted] and to [redacted]." The LPN stated that the resident was [redacted] with [redacted]

At 5:10 p.m., during the exit conference with the ED, in the presence of the Wellness Director, she stated that the facility will be changing residents' cabinet locks and had started to purchase these

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A 310	Continued From page 5 locks.	A 310		
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. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to implement and provide documentation for assessments, treatments, or physician instructions for 1 of 4 residents reviewed for safety, Resident #1. This deficient practice was evidenced by the following: On 7/28/21 at 9:30 a.m. the Department of Health (DOH) surveyed the facility regarding a reportable event concerning resident safety and the possible NJ Ex Order 26.4(b) of a NJ Ex Order 26.4(b)(1). On 7/28/2 at 9:30 a.m., during the entrance conference with the Executive Director (ED) and the Health and Wellness Director (HWD), the HWD stated that she was on vacation on NJ Ex Order 26.4 when Resident #1 was found NJ Ex Order 26.4(b)(1) [redacted]. At 9:50 a.m., Surveyor #1 also interviewed the ED regarding Resident #1's NJ Ex Order 26.4 incident when	A1073		

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the resident was found with a [NJ Ex Order 26.4(b)(1)] in his/her [NJ Ex Order]. The ED stated that on [NJ Ex Order 26.4(b)(1)], a care staff member informed her, the ED, and the Licensed Practical Nurse (LPN) that she, the care staff, found Resident #1 NJ Ex Order 26.4(b)(1) in the [NJ Ex Order] hall, near the dining/kitchen area. She stated that they immediately removed [NJ Ex Order 26.4(b)(1)] from Resident #1. Surveyor #1 asked the ED if the LPN and care staff member, who were present on [NJ Ex Order 26.4(b)(1)], could be interviewed, the ED stated that they were not working that survey day, 7/28/21, but that they still could be interviewed via telephone.

At 10:00 a.m., surveyor #1 asked the ED and the Director of Maintenance (DOM) to show the surveyor the NJ Ex Order 26.4(b)(1) that was found in Resident #1's hand. The DOM showed the surveyor a [NJ Ex Order 26.4(b)(1)] that had the name, NJ Ex Order 26.4(b)(1) " which was used as a NJ Ex Order 26.4(b)(1).

At 12:00 p.m., Surveyor #1 and Surveyor #2 interviewed Certified Nurse Aide #1 (CNA #1) who stated that everything, including all [NJ Ex Order 26.4(b)(1)] were kept locked and that she had been in-serviced on keeping [NJ Ex Order 26.4(b)(1)] locked. Surveyors asked CNA #1 if she was aware of Resident #1 being found NJ Ex Order 26.4(b)(1) [redacted]. CNA #1 stated that she was not working on [NJ Ex Order 26.4(b)(1)] when Resident #1 was [NJ Ex Order 26.4(b)(1)] [redacted]. The CNA also stated that Resident #1 likes to walk around NJ Ex Order 26.4(b)(1).

At 3:30 p.m., Surveyor #1 and #2 interviewed CNA #2 over the telephone regarding Resident #1's incident on [NJ Ex Order 26.4(b)(1)] when the resident was found with NJ Ex Order 26.4(b)(1) on his/her [NJ Ex Order] CNA #2 stated that as she was walking through

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the pass-through kitchen, near the dining area, at 11:00 a.m., she saw Resident #1 NJ Ex Order 26.4(b)(1) in the hall. She stated that she immediately NJ Ex Order 26.4(b)(1) from Resident #1 and notified the LPN and the ED. CNA #2 stated that the NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1) when she found it with Resident #1.

CNA #2 stated that Resident #1 was immediately placed on NJ Ex Order 26.4(b)(1) The surveyors asked CNA #2 to describe how they NJ Exec Order 26.4b1 the resident. CNA #2 stated that she performed "NJ Ex Order 26.4(b)(1) " of Resident #1 throughout her shift and that the resident was "NJ Ex Orde The surveyors asked CNA #2 to clarify "NJ Ex Order 26.4(b)(1) ." CNA #2 stated that she NJ Ex Order 26.4(b)(the resident while NJ Ex Order 26.4(b)(1) during daily activities.

At 3:50 p.m., during a telephone interview with Surveyors #1 and Surveyors #2, the LPN stated that CNA #2 informed the ED and her that Resident #1 was found NJ Ex Order 26.4(b)(1) . The LPN further stated that when she received the NJ Ex Order 26.4(b)(1) it was NJ Ex Order In addition, the LPN stated that she was not sure if Resident #1 NJ Ex Order 2 any of the NJ Ex Order 26.4(Surveyor #2 asked the LPN what action was taken after she received the NJ Ex Order 26.4(b)(1), the LPN stated that she had called NJ Ex Order 26.4(b)(1) right away and was instructed to NJ Ex Order 26.4 the resident every half-hour for any NJ Exec Order 26.4b1. In addition, the LPN stated that she "assessed" Resident #1 and that he/she was NJ Ex Or Surveyor #2 asked the LPN what assessment was performed. The LPN stated that she had taken Resident #1's vital signs which included NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4 to Resident #1's NJ Ex Order 26.4(b)(1) The surveyors asked the LPN for documentation or

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record of her findings, including the resident's vital signs. The LPN stated that she did not document Resident #1's vital signs in the medical record. Surveyors also asked the LPN if Resident #1's Physician was notified, the LPN stated that she could not remember. Surveyors also asked if she remembered what the physician instructed her do. The LPN again stated, she could not remember.

At 4:10 p.m., the surveyors interviewed the ED, who stated that she had called the HWD who was on vacation and informed her of the incident of Resident #1 being found NJ Ex Order 26.4(b)(1), while the LPN called the Physician and Resident #1's family. The ED also, stated that she was not aware of the conversation that was exchanged between Resident #1's physician and the LPN.

At 4:15 p.m., surveyor #1 reviewed Resident #1's medical record which showed that Resident #1 was admitted to the facility on NJ Ex Order 26 with multiple diagnoses that include NJ Ex Order 26.4(b)(1). Further review of Resident #1's medical record, titled, "Observation Notes" dated NJ Ex Order 26.4 at 3:45 p.m., showed that the Advanced Practice Nurse documented that Resident #1 was NJ Ex Ord and NJ Ex Order 26.4(b)(1). According to Resident #1's General Service Plan dated NJ Ex Order 26.4(b) Resident #1 NJ Ex Order 26.4(b)(1). Surveyor #1's review of Resident #1's NJ Ex Order 26.4(b)(1) Exam NJ Ex Ord) dated for NJ Ex Order 26.4, showed that the resident had a score of NJ Ex Ord which indicated NJ Ex Order 26.4(b)(1).

Surveyor #1's review of Resident #1's Observation Notes revealed the following:

1. The LPN documented on NJ Ex Order 26.4 at 11:00 a.m., the care giver came and gave her a NJ Ex Order

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NJ Ex Order 26.4(b)(1) that had been taken from Resident #1. The LPN further documented that a full assessment was completed, vital signs were NJ Ex Order 26 and there was NJ Ex Order 26.4(b)(1) noted to Resident #1's NJ Ex Order 26 In addition, the LPN documented that the NJ Ex Order 26.4 was called on the NJ Ex Order 26.4(b)(1) and NJ Exec Order 26.4b1 of Resident #1 every NJ Exec Order 26.4b through the shift. Further surveyor's review revealed that the LPN documented that Resident #1 had no complaints of NJ Ex Order 26.4 or NJ Ex Order 26.4(b and was NJ Ex Order 26.4(b)(1) of NJ Ex Order and NJ Ex Order 26.4(b)(1) without NJ Ex Order 26.4(and that Resident #1 would continue to be NJ Ex Order 26.4(b)(1)

2. The HWD documented on NJ Ex Order 26.4 at 11:30 a.m., that the RN was aware of possible NJ Ex Order 26.4(b) and that the LPN on duty had reported that Resident #1 had NJ Ex Order 26.4(b)(1) of NJ Ex Or or NJ Ex Order 26.4(b)(1) Also, that NJ Ex Order 26.4(b)(1) was notified, and that Resident #1 was being NJ Ex Order 26.4(b)(1 NJ Exec Order 26.4b1 In addition, Resident #1's power of attorney and physician was notified.

At 4:35 p.m., surveyor #1 interviewed the HWD regarding documentation in Resident #1's medical record. Surveyor #1 asked the HWD to explain how she documented on Resident #1 on NJ Ex Order 26.4 while she was off-site and on vacation. The HWD stated that she had off site access to the facility computer system. Surveyor #1 asked the HWD as to who called Resident #1's physician. The HWD stated that she was made aware that the LPN called Resident #1's physician.

At 5:15 p.m., upon further surveyor's review of Resident #1's medical record, there was no documented evidence on NJ Ex Order 26.4 of the following:

a. No documentation in Resident #1's medical

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A1073	Continued From page 10 record on who called Resident #1's physician nor the time the physician was called and what were the physician's instructions to address Resident #1's potential [redacted] of the [redacted] on [redacted]. b. No documentation in Resident #1's medical record that an actual RN assessment was conducted and completed on [redacted]. c. No documentation in Resident #1's medical record of the resident's vital signs and the [redacted] conducted every [redacted] on [redacted]. At 5:30 p.m. surveyor #1 and surveyor #2 asked the HWD to provide copies of the above documentation (a., b, and c.), the HWD was not able to provide documented evidence, as requested by the surveyors.	A1073		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
65a005 (Y1)	A. Building B. Wing (Y2)	9/8/2021 (Y3)

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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 A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 07/29/2021	ID Prefix A1073 Reg. # 8:36-15.6(b) LSC	Correction Completed 07/29/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
7/28/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO