

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>90a001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/03/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE LIVING AT SUMMIT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>41 SPRINGFIELD AVENUE SUMMIT, NJ 07901</b>
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(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	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ00172111</p> <p>CENSUS: 45</p> <p>SAMPLE SIZE: 3</p> <p>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.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

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

TITLE

(X6) DATE

04/26/24

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ00172111</p> <p>Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility's Executive Director (ED) failed to implement and enforce the policies and procedures titled, "Resident Assessment-New Jersey," and "Nursing Documentation/Service notes/Registered nurse role" regarding a resident's change in [redacted] for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>On 3/18/24 at 10:33 a.m., the surveyor reviewed the closed medical record (MR) of Resident #2, who moved into the facility on [redacted] with medical diagnoses that included [redacted]</p> <p>At 10:33 a.m. the surveyor reviewed a document titled, "Observations For [Resident #2] [redacted] NJ ex order 26.4b1," a progress note (PN) written by a Licensed Practical Nurse (LPN) on [redacted] NJ ex order 26.4b1 which noted Resident #2 [redacted] NJ ex order 26.4b1</p> <p>The LPN wrote that she notified the resident's son of the [redacted] NJ ex order 26.4b1 the PN did not reflect the Registered Nurse (RN) or the resident's Physician was notified of the resident's statement.</p> <p>At 12:30 p.m. the surveyor interviewed the</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>Wellness Director (WD), who is a Registered Nurse (RN), regarding the documented PN on <b>NJ ex order 26.4b1</b> written by the LPN. The WD stated that she could not recall being notified of Resident #2's <b>NJ ex order 26.4b1</b> on <b>NJ ex order 26.4b1</b>. The WD also stated that she, the RN, should have been notified of the resident's <b>NJ ex order 26.4b1</b>, which would have initiated an assessment. During continued interview with the WD she stated she had not re-assessed Resident #2, prior to <b>NJ ex order 26.4b1</b>, upon return to the facility on <b>NJ ex order 26.4b1</b> from the <b>NJ ex order 26.4b1</b> as she normally waits about five (5) days for the resident to reacclimate to the community.</p> <p>At 2:11 p.m. the surveyor interviewed the LPN who documented the PN on <b>NJ ex order 26.4b1</b>. The LPN stated she could not remember if she notified anyone else besides the son. The LPN confirmed the PN did not reflect the RN or the Physician being notified of the resident's <b>NJ ex order 26.4b1</b>. The LPN continued to state both the RN and the resident's Physician should have been notified of the resident's change in <b>NJ ex order 26.4b1</b>.</p> <p>Surveyor review of the following facility policies and procedures revealed for policy titled, 1. "Nursing Documentation/Service notes/Registered nurse role" with a revision date of 3/2012, which indicated, "Policy: To obtain and document meaningful information during the interview process and proved a baseline in the event there are changes in the resident's functional and/or cognitive status that would require additional services. Information is kept as a record of the resident's response to treatment/intervention and or incidents." Under, "Procedure: ...The professional nurse will be</p>	A 310		

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A 310	<p>Continued From page 3</p> <p>notified if there is a significant change in the resident's condition...The resident's physician of the physician's designee, that is another physician or an advanced practice nurse or physician's assistant shall be notified by the licensed nurse of any significant change in the resident's physicals or cognitive/mental condition and any intervention by the physician shall be documented. ..."</p> <p>2. Policy titled, "Resident Assessment-New Jersey" with a revision date of June 2014, indicated, under, "I. Purpose: "To assess each Resident and determine the physical and medical needs for each resident." Under, "II. Policy and Responsibilities: ...C. All residents shall have a re-assessment if there is a significant change in status. D. All residents shall have an assessment of their general service plan and note written upon readmission from the hospital by the RN [Registered Nurse]..."</p> <p>The facility failed to follow its own policies and procedures.</p> <p>On 3/20/24 at 5:19 p.m., the surveyor requested a removal plan from the ED for failing to implement facility's policies and procedures, including resident assessment which placed placed residents at risk for <span style="background-color: black; color: white; font-size: small;">NJ Ex Order 26.4(b)(1)</span>.</p> <p>The ED provided the survey team with an acceptable removal plan on 4/2/24.</p> <p>The surveyor completed a follow-up survey on 4/3/24 and confirmed that the facility implemented the removal plan.</p>	A 310		

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A 389 A 389	<p>Continued From page 4</p> <p>8:36-4.1(a)(16) Resident Rights</p> <p>(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:</p> <p>16. The right to be free from physical and mental abuse and/or neglect;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00172111</p> <p>Based on interview, record review, and pertinent facility documentation review, it was determined that the facility failed to ensure safety of a resident who was supposed to be monitored with a history of behaviors including, [redacted] and [redacted] starting around [redacted], and who had a history of [redacted] was enforced for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>On 3/13/24 at 4:40 p.m., the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJ DOH. The report included a document titled, "Incident date: [redacted]" which revealed a timeline of events that showed staff were not aware of Resident #2's [redacted] from 3:20 p.m. to 4:40 p.m. Resident #2 was [redacted] in</p>	A 389 A 389		

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A 389	<p>Continued From page 5</p> <p>his/her <b>NJ Ex Order 26.4(b)(1)</b> and at 4:40 p.m., the Resident was found in Resident #1's <b>NJ ex order 26.4b1</b> Resident #1 <b>NJ ex order 26.4b1</b>.</p> <p>A review of Resident #2's closed Medical Record (MR) revealed a document titled, "Resident Information" with a move in date of <b>NJ ex order 26.4b1</b>, with diagnoses which <b>NJ ex order 26.4b1</b>.</p> <p>A review of a document titled, "Observations For [Resident #2] <b>NJ ex order 26.4b1</b>" revealed the following Progress Notes (PNs):</p> <p>On 11/20/23 at 10:30 AM, the following documented note was observed in Resident #2's medical record written by LPN #1 and stated the following: "Resident <b>NJ ex order 26.4b1</b> ... <b>NJ ex order 26.4b1</b> ... <b>NJ ex order 26.4b1</b>." At 1:15 PM, the observation revealed the Resident <b>NJ ex order 26.4b1</b>.</p> <p>On 12/12/23 at 10:30 AM, the following documented note was observed in Resident #2's medical record written by LPN #1 and stated the following: "8 AM ... Resident ... repeatedly saying <b>NJ ex order 26.4b1</b> provided and the Resident</p>	A 389		
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A 389	<p>Continued From page 6</p> <p><b>NJ ex order 26.4b1</b></p> <p>[REDACTED]</p> <p>The following additional observations were also documented and reviewed:</p> <p>On [REDACTED] at 4:15 PM, <b>NJ Ex Order 26.4(b)(1)</b> to maintain [REDACTED] was noted.</p> <p>On [REDACTED] at 1:00 PM &amp; 8:30 PM, [REDACTED] done to prevent [REDACTED] and for [REDACTED]</p> <p>On [REDACTED] at 9:45 PM, <b>NJ Ex Order 26.4(b)(1)</b> to maintain [REDACTED]</p> <p>On [REDACTED] at 2:15 PM written by LPN #2 revealed the Resident needed [REDACTED] and [REDACTED] and noted with <b>NJ Ex Order 26.4(b)(1)</b>, [REDACTED] and [REDACTED]</p> <p>On [REDACTED] at 12:00 PM, [REDACTED] maintained for [REDACTED]</p> <p>On [REDACTED] at 10:45 AM revealed the Resident had acute changes in [REDACTED] was sent to the hospital for evaluation.</p> <p>On [REDACTED] at 3:30 PM, the Resident was transferred to a <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>On [REDACTED] at 11:15 AM revealed Resident #2 was readmitted to the facility from [REDACTED]</p> <p>Continued review of Observations for Resident #2 dated [REDACTED] written by LPN #2 revealed the Resident was noted with <b>NJ ex order 26.4b1</b></p> <p>[REDACTED]</p> <p>On 3/12/24 at 10:00 PM, observation noted, "Around 4:[;]45 PM care manager paged writer to room [REDACTED] [Resident #1's room, unoccupied], upon arrival resident <b>NJ ex order 26.4b1</b></p>	A 389		
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A 389	<p>Continued From page 7</p> <p>NJ ex order 26.4b1. NJ ex order 26.4b1 [his/her] NJ ex order 26.4b1 is [he/she] NJ ex order 26.4b1 [he/she] NJ ex order 26.4b1. NJ ex order 26.4b1</p> <p>NJ ex order 26.4b1</p> <p>On 3/15/24 at 12:00 PM, addendum noted, "... resident NJ ex order 26.4b1 "</p> <p>A review of documents titled, " NJ ex order 26.4b1 ", for " NJ ex order 26.4b1 ", for Resident #2 dated NJ ex order 26.4b1 and NJ ex order 26.4b1 all revealed under Diagnosis and Plan: " ... 4. NJ ex order 26.4b1 ... "</p> <p>During an interview on 3/20/2024 at 9:57 a.m., when the surveyor asked what close supervision means, LPN #2 stated when the Resident NJ ex order 26.4b1 him/her to NJ ex order 26.4b1, make sure needs are met and offer NJ Ex Order 26.4(b)(1) so he/she NJ ex order 26.4b1. In the same interview, when the surveyor asked what NJ Ex Order 26.4(b)(1) means, LPN #2 continued to say it means the Resident NJ ex order 26.4b1, there was always a staff member there to check on the Resident.</p> <p>In continued survey interview, when the surveyor asked for documentation to show a staff member is always present in the dayroom, LPN #2 stated it's not on the assignment. It is a verbal rotation agreement and it is not documented.</p>	A 389		
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A 389	<p>Continued From page 8</p> <p>During an interview at 10:43 a.m., when asked about <b>NJ Ex Order 26.4(b)(1)</b> for the Resident, LPN #1 stated there are no <b>NJ Ex Order 26.4(b)(1)</b>, most of the time they [the residents] are in the dayroom during the day. When the surveyor asked her about <b>NJ ex order 26.4b1</b> for Resident #2, she replied there was one care manager for him/her for <b>NJ ex order 26.4b1</b>, the care managers and nurses took turns to watch him/her. There was no log, it was only a verbal report and no documentation was done.</p> <p>During an interview at 12:38 p.m. when the surveyor asked about the <b>NJ ex order 26.4b1</b> for Resident #2, the Wellness Director, who is also the Director of Nursing (DON) stated the staff <b>NJ ex order 26.4b1</b> one on one supervision by keeping an eye on the Resident <b>NJ Ex Order 26.4(b)(1)</b>, a <b>NJ Ex Order 26.4b1</b> on him/her, staff would <b>NJ ex order 26.4b1</b> also seen by the Wellness Office or activity staff and/or walk with him/her. For Resident #2, depending on the behavior, staff would direct the Resident <b>NJ ex order 26.4b1</b>. The DON/WD continued to confirm all communication with staff was verbal, we do a stand up, stand down verbal report each shift, there was no documentation.</p> <p>In the same interview when the surveyor asked during <b>NJ Ex Order 26.4(b)(1)</b> and safety for Resident #2, the DON/WD stated he/she <b>NJ ex order 26.4b1</b>, so she said staff <b>NJ ex order 26.4b1</b> with him/her. She continued to say that <b>NJ ex order 26.4b1</b> are not documented, if the care manager and nurse did not see him/her, <b>NJ ex order 26.4b1</b></p>	A 389		

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A 389	<p>Continued From page 9</p> <p>During continued interview when the surveyor asked how the [redacted] and [redacted] was being monitored for Resident #2 as noted on the <b>NJ ex order 26.4b1</b> dated [redacted], the DON/WD repeated it was the same process by [redacted] on him/her.</p> <p>During an interview at 3:10 p.m., when verifying if there was no documentation of Resident #2's [redacted] how do you know it was done, the DON/WD stated staff would know it was done by talking to each other. She continued to say "I do know if not documented, it's not done is Nursing 101, but no way to prove it."</p> <p>At the time of survey, there were no policies on Behaviors.</p> <p>The facility [redacted] Resident #2 by [redacted] of his/her [redacted], who had a [redacted] [redacted] or [redacted] when Resident #2 [redacted]. Also, staff [redacted] from approximately 2:00 p.m. until the Resident [redacted] at 4:20 p.m. based on the FRE.</p> <p>On 3/20/24 at 5:19 p.m., the surveyor requested a removal plan from the ED for failing to implement facility's policies and procedures, including resident assessment which placed placed residents at risk for [redacted].</p> <p>The Administrator provided the survey team with an acceptable removal plan on 4/2/24.</p> <p>The surveyor completed a follow-up survey on 4/3/24 and confirmed the facility implemented the removal plan.</p>	A 389		

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A 709	<p>8:36-7.2(d)(1-18) Resident Assessments and Care Plans</p> <p>(d) Each health care assessment by the registered professional nurse shall include, at a minimum, evaluation of the following:</p> <ol style="list-style-type: none"> <li>1. Need for assistance with "activities of daily living";</li> <li>2. Cognitive patterns;</li> <li>3. Communication/hearing patterns;</li> <li>4. Vision patterns;</li> <li>5. Physical functioning and structural problems;</li> <li>6. Continence;</li> <li>7. Psychosocial well-being;</li> <li>8. Mood and behavior problems;</li> <li>9. Activity pursuit patterns;</li> <li>10. Disease diagnoses;</li> <li>11. Health conditions and preventive health measures, including, but not limited to, pain, falls, and lifestyle;</li> <li>12. Oral/nutritional status;</li> <li>13. Oral/dental status;</li> <li>14. Skin conditions;</li> <li>15. Medication use;</li> </ol>	A 709		

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A 709	<p>Continued From page 11</p> <p>16. Special treatment and procedures;</p> <p>17. Restraint use;</p> <p>18. Outside service utilization.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00172111</p> <p>Based on interview, record review, and pertinent facility documentation review on 3/20/24, it was determined that the facility failed to have an assessment done by a Registered Nurse (RN) for 1 of 3 residents, Resident #2. This deficient practice was evidenced by the following:</p> <p>On 03/20/24, the surveyor reviewed the Medical Record (MR) of Resident #2 which revealed a document titled, "Resident Information" with a move in date of [redacted] with diagnoses which included [redacted]</p> <p>A review of a document titled, "Observations For [Resident #2] [redacted]", revealed a Progress Note (PN) dated [redacted] at 11:15 AM that the Resident [redacted]</p> <p>The surveyor reviewed Resident #2's "NJ Assessment 60 Day Assessment dated [redacted]</p>	A 709		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>90a001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>04/03/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE LIVING AT SUMMIT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>41 SPRINGFIELD AVENUE SUMMIT, NJ 07901</b>
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(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
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A 709	<p>Continued From page 12</p> <p>with a next due date: <sup>NJ ex order 26.4b1</sup>, under "General Services" included, <sup>NJ ex order 26.4b1</sup></p> <p>[REDACTED]</p> <p>Further review of the document revealed the following information: Under <sup>NJ Ex Order 26.4(b)</sup> "Patterns" included, <sup>NJ ex order 26.4b1</sup> [REDACTED] Resident's Needs/Preferences: <sup>NJ ex order 26.4b1</sup> [REDACTED]</p> <p>Questions were included to assess if the Resident had the following:</p> <p>Under <sup>NJ Ex Order 26.4(b)(1)</sup>, "The box was checked <sup>NJ ex order 26.4b1</sup>"</p> <p>Under <sup>NJ Ex Order 26.4(b)(1)</sup> the box was checked <sup>NJ ex order 26.4b1</sup></p> <p>Under <sup>NJ Ex Order 26.4(b)</sup> the box was checked <sup>NJ ex order 26.4b1</sup></p> <p>Under <sup>NJ Ex Order 26.4(b)(1)</sup> Resident's Needs and Preferences: <sup>NJ ex order 26.4b1</sup> [REDACTED] he/she <sup>NJ ex order 26.4b1</sup>, <sup>NJ ex order 26.4b1</sup> ...Resident's Desired Goals &amp; Outcomes: <sup>NJ ex order 26.4b1</sup> [REDACTED]"</p> <p>Under <sup>NJ Ex Order 26.4(b)(1)</sup> the box was checked "No." Under <sup>NJ Ex Order 26.4(b)(1)</sup>, "Resident's Needs/Preferences: <sup>NJ ex order 26.4b1</sup> [REDACTED] Resident's Desired Goals &amp; Outcomes: <sup>NJ ex order 26.4b1</sup> ..."</p> <p>Under <sup>NJ Ex Order 26.4(b)(1)</sup>, "Resident's Needs/Preferences: <sup>NJ ex order 26.4b1</sup> [REDACTED]"</p>	A 709		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>90a001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/03/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE LIVING AT SUMMIT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>41 SPRINGFIELD AVENUE SUMMIT, NJ 07901</b>
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A 709	<p>Continued From page 13</p> <p>Goals &amp; Outcomes: resident <b>NJ ex order 26.4b1</b> Under "Current signs &amp; symptoms," the box is checked <b>NJ ex order</b></p> <p>At the time of survey, there was no documented evidence of interventions listed to accomplish these goals and outcomes for Resident #2 on the 60 day Assessment/General Service Plan (GSP).</p> <p>During an interview on 3/20/24 at 12:38 p.m., when the surveyor asked about the GSP, the box for <b>NJ Ex Order 26.4(b)(1)</b> was checked as <b>NJ ex order</b> for Resident #2, the Director of Nursing/Wellness Director (DON/WD) stated I completed it per the <b>NJ ex order 26.4b1</b>, which is part of the assessment.</p> <p>In the same interview, when the surveyor showed her the 60 day Assessment, under GSP having no interventions for Resident #2, the DON/WD confirmed, she agreed there are no interventions on the GSP, there are usually interventions and she was not sure why.</p> <p>A review of the facility policy titled, "Resident Assessment-New Jersey" with a revised date June 2014, revealed the following: under, "I. Purpose: "To assess each Resident and determine the physical and medical needs for each resident. ... II. Policy and Responsibilities: ...B. The Wellness Director or designee will complete a full assessment prior to admission, on admission or within the state required time frame to determine the resident's needs. ... III. Procedure: ...B. Based upon the assessment the service plan will be initiated as applicable ..."</p>	A 709		
A 735	8:36-7.2(e)(1-5) Resident Assessments and Care Plans	A 735		

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NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE LIVING AT SUMMIT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>41 SPRINGFIELD AVENUE SUMMIT, NJ 07901</b>
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A 735	<p>Continued From page 14</p> <p>(e) Based on the health care assessment, a written health service plan shall be developed. The health service plan shall include, but not be limited to, the following:</p> <ol style="list-style-type: none"> <li>1. Orders for treatment or services, medications, and diet, if needed;</li> <li>2. The resident's needs and preferences for himself or herself;</li> <li>3. The specific goals of treatment or services, if appropriate;</li> <li>4. The time intervals at which the resident's response to treatment will be reviewed; and</li> <li>5. The measures to be used to assess the effects of treatment.</li> </ol> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ000172111</p> <p>Based on interview, and record review, it was determined that the facility failed to implement a Health Service Plan (HSP) for 1 of 3 residents (Resident #2) who had a <b>NJ ex order 26.4b1</b>, <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4(b)(1)</b>. This deficient practice was evidenced by the following:</p> <p>On 03/20/24, the surveyor reviewed the closed Medical Record (MR) of Resident #2 which</p>	A 735		

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NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE LIVING AT SUMMIT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>41 SPRINGFIELD AVENUE SUMMIT, NJ 07901</b>
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A 735	<p>Continued From page 15</p> <p>revealed a document titled, "Resident Information" with a move in date of [redacted] and diagnoses which [redacted]</p> <p>[redacted]</p> <p>A review of a document titled, "Observations For [Resident #2] [redacted]," revealed a Progress Note (PN) dated [redacted] at 11:15 AM revealed the Resident was [redacted]</p> <p>[redacted]</p> <p>The surveyor reviewed Resident #2's "NJ Assessment 60 Day Assessment dated [redacted] with a next due date: [redacted] that revealed the following:</p> <p>Under, "NJ Ex Order 26.4(b)(1)" included " [redacted] ... Resident's Needs/Preferences: [redacted] ...Resident's Desired Goals &amp; Outcomes: [redacted] "</p> <p>Under, "NJ Ex Order 26.4(b)(1)," the box was checked [redacted]</p> <p>Under, "NJ Ex Order 26.4(b)(1)" the box was checked [redacted]</p> <p>Under, "NJ Ex Order 26.4(b)" the box was checked [redacted].</p> <p>Under, "NJ Ex Order 26.4(b)(1)" ... Resident's Needs and Preferences: [redacted] ...Resident's Desired Goals &amp; Outcomes: [redacted] "</p> <p>Under "NJ Ex Order 26.4(b)(1)" the box was checked [redacted]</p>	A 735		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>90a001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/03/2024</b>
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A 735	<p>Continued From page 16</p> <p>Under 'NJ Ex Order 26.4(b)(1) ... Resident's Needs/Preferences: NJ ex order 26.4b1 [redacted] Resident's Desired Goals &amp; Outcomes: NJ ex order 26.4b1 ...' Under 'NJ Ex Order 26.4(b)(1) ... Resident's Needs/Preferences: NJ ex order 26.4b1 [redacted], Resident's Desired Goals &amp; Outcomes: NJ ex order 26.4b1 [redacted] ...' Under "Current signs &amp; symptoms," the box is checked NJ ex order 26.4b1 [redacted]."</p> <p>During an interview on 3/20/24 at 12:38 p.m., when the surveyor asked if Resident #2 had a Health Service Plan (HSP) for NJ ex order 26.4b1 [redacted], the Director of Nursing/Wellness Director (DON/WD) stated no residents have NJ Ex Order 26.4(b)(1) [redacted] HSPs. If any resident would warrant a HSP for NJ Ex Order 26.4(b)(1) [redacted] then this is not the place for them. She continued to say, when a resident has NJ Ex Order 26.4(b)(1) [redacted] [they are] is on [the] assessment and General Service Plan (GSP) and then followed up with NJ Ex Order 26.4(b)(1) [redacted].</p> <p>In the same interview, the DON/WD stated there was no need for Resident #2 to have a NJ Ex Order 26.4(b)(1) [redacted] HSP for NJ ex order 26.4b1 [redacted] because she could handle his/her NJ ex order 26.4b1 [redacted], the NJ ex order 26.4b1 [redacted] were on the GSP.</p> <p>A review of the facility policy titled, "Nursing Practice New Jersey" with a revised date December 2008, revealed the following: Under, "I. Policy: All residents will have their service plan needs reassessed at least semiannually or more often if needed. Those residents with Health service plans shall have their health service plans reassessed at least quarterly. The condition of residents shall be monitored on a periodic basis but at least monitored during wellness checks ..."</p>	A 735		

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A 735	Continued From page 17  A review of the facility policy titled, "Resident Assessment-New Jersey" with a revised date June 2014, revealed the following: "I. Purpose: "To assess each Resident and determine the physical and medical needs for each resident. ... II. Policy and Responsibilities: ...C. All residents shall have a re-assessment if there is a significant change of status ... III. Procedure: ... B. Based upon the assessment the service plan will be initiated as applicable ..."	A 735		
A 779	8:36-7.5(c) Resident Assessments and Care Plans  (c) The registered professional nurse shall be called at the onset of illness, injury or change in condition of any resident to arrange for assessment of the resident's nursing care needs or medical needs and for needed nursing care intervention or medical care.  This REQUIREMENT is not met as evidenced by: Complaint#: NJ00172111  Based on interview, and closed medical record review, it was determined that the facility's Licensed Practical Nurse (LPN) failed to notify the Registered Nurse (RN) of a resident's [redacted] for 1 of 3 residents reviewed, Resident #2. The deficient practice was evidenced by the following:  On 3/18/24 at 10:33 a.m. the surveyor reviewed	A 779		

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A 779	<p>Continued From page 18</p> <p>the closed medical record (MR) of Resident #2, who moved into the facility on [redacted] with medical diagnoses <b>NJ ex order 26.4b1</b> [redacted]</p> <p>Continued review of Resident #2's MR revealed a document titled, "Observations For [Resident #2] <b>NJ ex order 26.4b1</b>" The document contained a progress note (PN) written by an LPN on [redacted] in which Resident #2 <b>NJ ex order 26.4b1</b> " <b>NJ ex order 26.4b1</b> " The LPN documented that she notified the resident's son of the resident's statement.</p> <p>At 2:11 p.m. the surveyor interviewed the LPN who documented the PN on [redacted]. The LPN stated she could not remember if she notified anyone else besides the son. The LPN confirmed the PN did not reflect the RN being notified of the resident's <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>At 2:36 p.m. the surveyor interviewed the Wellness Director (WD), who is an RN, about the documented PN on [redacted] written by the LPN. The WD stated that she could not recall being notified of Resident #2's <b>NJ ex order 26.4b1</b> statement on [redacted]. The WD continued to state that she, the RN, should have been notified of the resident's <b>NJ ex order 26.4b1</b>, which would have initiated a need for assessment.</p> <p>The facility failed to provide documented evidence the RN was notified of Resident #2's <b>NJ ex order 26.4b1</b>.</p> <p>On 3/20/24 at 5:19 p.m., the surveyor requested a <b>NJ ex order 26.4b1</b> from the ED for failing to implement facility's policies and procedures, including resident assessment which placed</p>	A 779		

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A 779	Continued From page 19 placed residents at risk for <span style="background-color: black; color: black;">NJ Ex Order 26.4(b)(1)</span> .  The Executive Director provided the survey team with an acceptable removal plan on 4/2/24.  The surveyor completed a follow-up survey on 4/3/24 and confirmed that the facility implemented the removal plan.	A 779		
A 781	8:36-7.5(d) Resident Assessments and Care Plans  (d) The resident's physician or the physician's designee, that is, another physician or an advanced practice nurse or physician assistant, shall be notified by the licensed professional nurse of any significant changes in the resident's physical or cognitive/mental condition and any intervention by the physician shall be recorded.  This REQUIREMENT is not met as evidenced by: Complaint#: NJ00172111  Based on interview, and closed medical record, review it was determined that the facility failed to notify the physician of a resident's <span style="background-color: black; color: black;">NJ ex order 26.4b1</span> for 1 of 3 residents reviewed, Resident #2. The deficient practice was evidenced by the following:  On 3/18/24 at 10:33 a.m., the surveyor reviewed the closed medical record (MR) of Resident #2, who moved into the facility in <span style="background-color: black; color: black;">NJ ex order 26.4b1</span> with medical diagnoses <span style="background-color: black; color: black;">NJ ex order 26.4b1</span>	A 781		

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A 781	<p>Continued From page 20</p> <p><b>NJ ex order 26.4b1</b></p> <p>Continued review of Resident #2's MR revealed a document titled, <b>NJ Ex Order 26.4(b)(1)</b> For [Resident #2] <b>NJ ex order 26.4b1</b>." The document contained a progress note (PN) written by an Licensed Practical Nurse (LPN) on <b>NJ ex order 26.4b1</b> in which Resident #2 <b>NJ ex order 26.4b1</b> " .... <b>NJ ex order 26.4b1</b> The LPN wrote that she notified the resident's son of the resident's statement.</p> <p>At 2:11 p.m. the surveyor interviewed the LPN who documented the PN on <b>NJ ex order 26.4b1</b>. The LPN stated she could not remember if she notified anyone else besides the son. The LPN confirmed the PN did not reflect the resident's physician being notified of the resident's expressed <b>NJ Ex Order 26.4b1</b>.</p> <p>The facility failed to provide documented evidence the Physician was notified of Resident #2 <b>NJ ex order 26.4b1</b>.</p> <p>On 3/20/24 at 5:19 p.m., the surveyor requested a removal plan from the ED for failing to implement facility's policies and procedures, including resident assessment which placed placed residents at risk for <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>The Executive Director provided the survey team with an acceptable removal plan on 4/2/24.</p> <p>The surveyor completed a follow-up survey on 4/3/24 and confirmed that the facility implemented the removal plan.</p>	A 781		
A 935	8:36-11.4(b) Pharmaceutical Services	A 935		

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A 935	<p>Continued From page 21</p> <p>(b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: #NJ00172111</p> <p>Based on interview, and record review, it was determined that the facility failed to ensure that medications were reconciled (process of comparing a resident's medication orders to all of the medications that the resident was taking) with the previous facility medications and followed up with the physician for a resident who was <b>NJ ex order 26.4b1</b> for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>A review of Resident #2's closed Medical Record (MR) revealed a document titled, "Resident Information" with a move in date of <b>NJ ex order 26.4b1</b>, and diagnoses which <b>NJ ex order 26.4b1</b></p>	A 935		

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(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
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A 935	<p>Continued From page 22</p> <p>A review of a document titled, "Observations For [Resident #2] <b>NJ ex order 26.4b1</b>," revealed Progress Notes (PNs) that included the following:</p> <p>On 1/16/24, the Resident was <b>NJ ex order 26.4b1</b> was <b>NJ ex order 26.4b1</b>, and on <b>NJ ex order 26.4b1</b>, the Resident was readmitted to the facility.</p> <p>A review of documents titled, <b>NJ Ex Order 26.4(b)(1)</b> Associates," <b>NJ ex order 26.4b1</b>, for Resident #2 dated <b>NJ ex order 26.4b1</b> and <b>NJ ex order 26.4b1</b> all revealed under: "Diagnosis and Plan: ...2. <b>NJ ex order 26.4b1</b> 3. <b>NJ ex order 26.4b1</b> ..."</p> <p>A review of Resident #2's "Scheduled Medications" dated <b>NJ ex order 26.4b1</b>, revealed the following medications:</p> <p><b>NJ Ex Order 26.4(b)(1)</b> Tablet Oral (by mouth) Take 2 tablets <b>NJ Ex Order 26.4b1</b> by mouth at bedtime</p> <p><b>NJ Ex Order 26.4(b)(1)</b> Tablet <b>NJ Ex Order 26.4(b)(1)</b> Tablet) Oral (by mouth) Take 1 Tablet by mouth daily at bedtime</p> <p>A review of Resident #2's "Resident Information" sheet dated <b>NJ ex order 26.4b1</b>, included under "Medication Orders (MOs)" revealed the following active orders as of <b>NJ ex order 26.4b1</b></p> <p><b>NJ Ex Order 26.4(b)(1)</b> Tab <b>NJ Ex Order 26.4(b)(1)</b> Tablet) Oral (by mouth) Take 1 tablet by mouth at bedtime</p> <p><b>NJ Ex Order 26.4(b)(1)</b> <b>NJ Ex Order 26.4(b)(1)</b> ) oral (by mouth), Take 1 <b>NJ Ex Order 26.4b1</b> by mouth in the evening</p>	A 935		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>90a001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/03/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE LIVING AT SUMMIT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>41 SPRINGFIELD AVENUE SUMMIT, NJ 07901</b>
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(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 935	<p>Continued From page 23</p> <p><b>NJ Ex Order 26.4(b)(1)</b> Tablet Oral (by mouth) Take 1 tablet by mouth twice a day Active as of <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p><b>NJ Ex Order 26.4(b)(1)</b> Tablet (<b>NJ Ex Order 26.4(b)(1)</b>) Tablet) Oral (by mouth), Take 1 tablet by mouth twice a day</p> <p><b>NJ Ex Order 26.4(b)(1)</b> Tab Tab <b>NJ Ex Order 26.4(b)(1)</b> Tablet) Oral (by mouth), Take 1 tablet by mouth once daily</p> <p><b>NJ Ex Order 26.4(b)(1)</b> Tablet Oral (by mouth) Take 2 tablets by mouth daily</p> <p><b>NJ Ex Order 26.4(b)(1)</b> Tablet (<b>NJ Ex Order 26.4(b)(1)</b>) Tablet) Oral (by mouth) Take 1 tablet by mouth once daily</p> <p><b>NJ Ex Order 26.4(b)(1)</b> <b>NJ Ex Order 26.4(b)(1)</b> ) Oral (by mouth), Take 1 <b>NJ Ex Order 26.4(b)(1)</b> by mouth at bedtime</p> <p>A review of Resident #2's medications at the time of his/her <b>NJ ex order 26.4b1</b> did not include the <b>NJ Ex Order 26.4(b)(1)</b> and <b>NJ Ex Order 26.4(b)(1)</b> medications as previously prescribed in <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>During an interview on 3/20/24 at 12:38 p.m., when the surveyor asked about the missing medications on Resident #2's <b>NJ ex order 26.4b1</b>, <b>NJ ex order 26.4b1</b> the Director of Nursing/Wellness Director (DON/WD) said Resident #2 <b>NJ ex order 26.4b1</b>, the facility sent a list of meds [medications] to the hospital, but she did not know what happened to the <b>NJ ex order 26.4b1</b>, then he/she <b>NJ ex order 26.4b1</b>. <b>NJ ex order 26.4b1</b> When asked about the process of</p>	A 935		



New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>90a001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/03/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRANDYWINE LIVING AT SUMMIT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>41 SPRINGFIELD AVENUE SUMMIT, NJ 07901</b>
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(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 935	<p>Continued From page 24</p> <p>reconciling medications, the DON/WD stated the Licensed Practice Nurse (LPN) reconciles meds and gets [physician] orders and compares the medications to the previous facility medications and the facility psychiatrist would have reviewed the medications for the [redacted]</p> <p>During a second interview at 3:10 p.m., the DON/WD stated, "the nurse should have looked back at the [redacted] and compared to [the] readmit [readmission] meds in [redacted], then consulted the doctor [physician] to see if the meds should occur with the primary doctor (PD), then PD would tell the nurse to follow up with the [redacted]</p> <p>During continued surveyor interview, when asked if Resident #2 [redacted] schedule for Monday if he/she returned on a [redacted], the DON/WD didn't know. She continued to say, the nurse who [redacted] Resident #2 should have contacted the psychiatrist within 24 hours of the Resident's return and the nurse would have documented this contact in the nurse's note. The DON/WD added the [redacted] [redacted]</p> <p>At the time of survey, there was no evidence that the physician or [redacted] was contacted and informed of the missing medications.</p>	A 935		

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 90a001	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 5/15/2024
NAME OF FACILITY BRANDYWINE LIVING AT SUMMIT		STREET ADDRESS, CITY, STATE, ZIP CODE 41 SPRINGFIELD AVENUE SUMMIT, NJ 07901

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	Correction	ID Prefix A0389	Correction	ID Prefix A0709	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-7.2(d)(1-18)	Completed
LSC	05/17/2024	LSC	05/17/2024	LSC	05/17/2024
ID Prefix A0735	Correction	ID Prefix A0779	Correction	ID Prefix A0781	Correction
Reg. # 8:36-7.2(e)(1-5)	Completed	Reg. # 8:36-7.5(c)	Completed	Reg. # 8:36-7.5(d)	Completed
LSC	05/17/2024	LSC	05/17/2024	LSC	05/17/2024
ID Prefix A0935	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-11.4(b)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/17/2024	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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 4/3/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		
		<input type="checkbox"/> YES <input type="checkbox"/> NO		