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
	55A112	A. BUILDING: ______ B. WING ______	11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT WALL	**2021 HIGHWAY 35 WALL, NJ 07719**

(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: A COVID-19 Focused Infection Control Survey was conducted by the State Agency on 11/10/2020. The facility was found not to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The census was 78. 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		
A1271	8:36-18.1(a) Infection Prevention and Control Services (a) The facility shall develop and implement an infection prevention and control program. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, facility policy, and New Jersey Department of Health guidelines, the facility failed to isolate four of four newly admitted residents (Residents #4, #5, #6, and #7) for 14 days and to have staff wear	A1271		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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BRANDYWINE LIVING AT WALL	**2021 HIGHWAY 35 WALL, NJ 07719**

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A1271	Continued From page 1 appropriate personal protective equipment (PPE). The facility census was 85. Findings included: According to the New Jersey Department of Public Health guidance, "Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities, " dated 10/22/20, indicated, "Full Transmission-Based Precautions and all recommended COVID-19 PPE should be used for all patients/residents who are: New and re-admissions." It further indicated that new admissions and readmissions are placed in, "Cohort 4," which "serves as an observation area where persons remain for 14 days to monitor for symptoms that may be compatible with COVID-19." COVID-19 recommended PPE included, "N95 respirator or higher [or facemask if unavailable], eye protection, gloves, and isolation gown." Resident #4 and Resident #5 Executive Orde Executive Order 26, 4.b. . An observation on 11/13/2020 at 11:15 AM indicated there was no PPE inside or outside the room. There was no signage on the room door indicating PPE was needed to enter the residents' room. Resident #6 Executive Order 26, 4.b. e Order 26, 4.b.. An observation on 11/10/2020 at 11:17 AM indicated there was no PPE inside or outside the room. There was no signage on the room door indicating PPE was needed to enter the resident's room. Resident #7 Executive Order 26, 4.b. An observation on 11/10/2020 at 11:20 AM indicated there was no PPE inside or outside the room.	A1271		

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	55A112	A. BUILDING: ______ B. WING ______	11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT WALL	**2021 HIGHWAY 35** **WALL, NJ 07719**

(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
A1271	Continued From page 2 There was no signage on the room door indicating PPE was needed to enter the resident's room. The Director of Nursing (DON), interviewed on 11/10/2020 at 11:30 AM, stated that Resident #4, Resident #5, Resident #6 and Resident # [redacted] The DON confirmed the residents were [redacted] as directed in the facility's infection control policies. A review of the facility's policy titled "COVID-19 Outbreak Plan," revised on 06/16/2020, directed staff "15. All staff will use full PPE when entering any resident room who is considered ill or exposed."	A1271		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
55A112 Y1	A. Building B. Wing Y2	12/7/2020 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT WALL	2021 HIGHWAY 35 WALL, NJ 07719

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 A1271 Reg. # 8:36-18.1(a) LSC	Correction Completed 12/03/2020	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
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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 11/10/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			