STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07A021	A. BUILDING: _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT LIVINGSTON	369 EAST MT PLEASANT AVENUE LIVINGSTON, NJ 07039

(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 #: NJ00186472 CENSUS: 97 SAMPLE SIZE: 3 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 357	8:36-4.1(a)(2) 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: 2. The right to receive a level of care and services that addresses the resident's changing physical and psychosocial status;	A 357		

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

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A 357	Continued From page 1	A 357		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00186472

Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide a resident with a level of care and services that addressed changes in his/her [NJ Exec Order 26.4b1] status for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On 5/19/25, the Department of Health received a Reportable Event Record (RER) completed by the Regional Director of Operations on [NJ Exec Order 26.4], for an [NJ Exec Order 26.4b1] that occurred on [NJ Exec Order 26.4]. The RER indicated that Resident #2 [NJ Exec Order 26.4b1] at 12:34 a.m. through the [NJ Exec Order 26.4b1]. The RER also indicated that at 1:33 a.m., [NJ Ex Order 26.4(b)(1)] called a Licensed Practical Nurse (LPN) at the facility and asked of Resident #2's [NJ Ex Order 26.4(b)(1)] In addition, the RER indicated that [NJ Exec Order] arrived at the facility and notified the night shift staff that Resident #2 was involved in a [NJ Exec Order 26.4b1] [redacted] as a [NJ Exec Order 26.4b1] and was [NJ Exec Order 26.4] [redacted]. Lastly, the RER indicated that at 8:30 a.m., the facility was notified that Resident #2 [NJ Exec Order 26.4]

The surveyor reviewed the Medical Record (MR) of Resident #2, who was admitted to the facility in [NJ Exec O] of [NJ Exec Ord] with a diagnosis of [NJ Exec Order 26.4b1] [redacted] The surveyor reviewed Resident #2's "Physician's Order Report," which revealed that the resident had an order for [NJ Exec Order 26.4b1] [redacted] two times a day. The order report also revealed that Resident #2 was started

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A 357	Continued From page 2 on memantine on [NJ Exec Order 26.4b1] In addition, the surveyor reviewed Resident #2's bi-annual assessment dated [NJ Exec Order 26.4b1], which indicated that the resident [NJ Exec Order 26.4b1] "occasional staff [NJ Exec Order 26.4b1] and/or reorientation for their current or [NJ Exec Order 26.4b1]." The assessment also indicated that Resident #2 scored [NJ Exec Order 26.4b1] out of [NJ Exec Order 26.4b1] points on his/her [NJ Exec Order 26.4b1] which indicated that the resident was "at [NJ Exec Order 26.4b1] for [NJ Exec Order 26.4b1] and requires staff assistance through regular interventions." Further, the surveyor reviewed Resident #2's individual service plan dated [NJ Exec Order 26.4b1] which indicated that Resident #2 was an [NJ Exec Order 26.4b1] risk who required [NJ Exec Order 26.4b1] assistance. However, the service plan did not document interventions to [NJ Exec Order 26.4b1]. Further review of Resident #2's MR revealed that a PN dated [NJ Exec Order 26.4b1], written by Registered Nurse (RN) #1, indicated, "Resident seen [NJ Exec Order 26.4b1] the [NJ Exec Order 26.4b1] with a [NJ Exec Order 26.4b1] Resident is [NJ Exec Order 26.4b1] with episodes of [NJ Exec Order 26.4b1] ... Resident [NJ Exec Order 26.4b1] to [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] to [his/her] room with staff [NJ Exec Order 26.4b1] ..." The surveyor reviewed another PN dated [NJ Exec Order 26.4b1], written by LPN #1, which indicated, "... the resident was [NJ Exec Order 26.4b1] in bed. When asked, the resident stated, 'I think I am [NJ Exec Order 26.4b1] and I do not know [NJ Exec Order 26.4b1] Resident was [NJ Exec Order 26.4b1] or [NJ Exec Order 26.4b1] ...." In addition, the surveyor reviewed a PN dated [NJ Exec Order 26.4b1], written by RN #1, which indicated, "Resident received in [NJ Exec Order 26.4b1] with [NJ Exec Order 26.4b1] of [NJ Exec Order 26.4b1] ..."	A 357		

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A 357	Continued From page 3 The surveyor then reviewed a PN dated [NJ Exec Order 26.4], written by RN #1, which indicated, "Call placed to medical group due to resident's [NJ Exec Order 26.4b1] wellness nurse requested an order for NJ Exec Order 26.4b1. ..." The surveyor reviewed a PN dated [NJ Exec Order 26], written by RN #1, which indicated, "... [NJ Exec Order 26.4b1]: [NJ Exec] ... Further, the surveyor reviewed a PN dated [NJ Exec Order 26.4], written by LPN #2, which indicated, "Around 6:45 AM the concierge paged me for assistance in the lobby area. She stated she observed [Resident #2] NJ Exec Order 26.4b1 ...." The surveyor then reviewed a PN dated [NJ Exec Order 2], written by the Assistant Health and Wellness Director (Registered Nurse) (AHWD), which indicated, "Received a call from concierge around 1 PM stating that resident is in the lobby stating that NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1). When asked who [he/she] wants to talk to resident stated that NJ Ex Order 26.4(b)(1). Writer attempted several times to redirect resident unsuccessfully ... MD [Medical Doctor] will send new order to start [NJ Exec Order 26.4b1] [also known as NJ Exec Order 26.4b1] ..." The surveyor reviewed a PN dated [NJ Exec Order 26.4b1] written by RN #1, which indicated, "Around 7 p.m. concierge called wellness nurse's attention stating that resident NJ Exec Order 26.4b1 Team asked who was [NJ Exec Order 26] that [the resident] needed to [NJ Exec] but [he/she] did not respond. Resident [NJ Exec Order 26.4b1] several times, but [the resident] NJ Exec Order 26.4b1 ...	A 357		

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A 357	Continued From page 4 The surveyor reviewed a PN dated 5/8/25, written by LPN #2, which indicated that the LPN received a phone call from a NJ Exec Order 26.4b1 who inquired if Resident #2 resided at the facility. The PN indicated that the LPN confirmed that Resident #2 lived at the facility and that the NJ Exec Order 26.4b then stated that an NJ Exec Order would come to the facility to NJ Exec Order the resident's room. The PN indicated that the LPN went to Resident #2's room, and the resident NJ Exec Order 26.4b1. Lastly, the PN indicated that the LPN was met by a NJ Exec Order 26.4b1 in the facility's lobby area, and that the NJ Exec Order 26.4b1 requested information. The surveyor reviewed another PN dated NJ Exec Order, written by the AHWD, which indicated, "Received a call at 1:51 AM from NOD [nurse on duty] reporting that NJ Exec Order 26.4b1 came in to alert community that resident was NJ Exec Orde on the NJ Exec Orde where [he/she] was NJ Exec Order by a NJ Exec Order 26 and NJ Exec Order 26.4b1 ... resident was taken to hospital ...." The surveyor reviewed an additional PN dated NJ Exec Order, written by the AHWD, which indicated, "... Around 8:30 AM writer received a call from [hospital] reporting that resident had NJ Exec Order 26. ..." At 10:02 a.m., the surveyor interviewed the Executive Director (ED), who started at the facility on NJ Exec Order 26.4b, to inquire about Resident #2's NJ Exec Order 26.4b1 on NJ Exec Order 26. The ED stated that Resident #2 NJ Exec Order 26 from the facility and that the resident should have been in NJ Exec Order 26.4b1. The ED stated that a nursing assessment was supposed to be completed in order to transition Resident #2 into "Reflections," which was the facility's NJ Exec Order 26.4b1 unit. Additionally, the ED stated that Resident #2's family was NJ Exec Order 26.4b to	A 357		

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the transition and that the [NJ Exec Order 26.4b1] happened during this time. The ED stated that Resident #2 [NJ Exec Order 26.] from the facility, was [NJ Exec Order 26.4b1], and later [NJ Exec Order 26.] due to his/her [NJ Exec Order 26.4] The ED stated that he was not the ED at the facility when the [NJ Exec Order 26.4b1] took place and that he did not know all the details about the incident.

At 10:37 a.m., the surveyor interviewed the Regional Director of Wellness (DOW), who was the acting DOW starting [NJ Exec Order 26.], to inquire about the previously mentioned [NJ Exec Order 26.4b1] The DOW stated that on [NJ Exec Order 26.] she missed a phone call from the AHWD. The DOW stated that she returned the AHWD's phone call and was informed that LPN #2 called the AHWD and stated that Resident #2 was [NJ Exec Order] by a [NJ Exec Order 26.] and was taken to the hospital. The DOW then stated that at 8:30 a.m., the facility received a phone call from the hospital, who notified staff that Resident #2 [NJ Exec Order 26.4] The surveyor inquired if facility staff noticed any changes with Resident #2, and the DOW stated that after the incident, she was informed by staff that Resident #2 had [NJ Exec Order 26.4b1]. The DOW stated that she later reviewed Resident #2's PNs and discovered incidents where the resident displayed [NJ Exec Order 26.4b1]

At 11:47 a.m., 12:04 p.m., and 12:11 p.m., the surveyor interviewed Caregivers #1, 2, and 3 respectively to inquire about Resident #2. Caregiver #1 stated that Resident #2 was [NJ Exec Orde] when he/she started at the facility and that the resident later started to show signs of [NJ Exec Order 26.4b1] Caregiver #1 explained that Resident #2 was initially [NJ Exec Order 26.4b1] but later required [NJ Exec Order 26.4b1] with some activities of daily living, including getting [NJ Exec Order 26.4b] Caregiver #1 also stated that about a [NJ Exec Order 26.4b1] Resident #2 put a [NJ Exec Order] on as [NJ Exec Order] Caregiver #1 stated that she reported

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Resident #2's NJ Exec Order 26.4b1 to the nurse but was not able to remember which nurse.

Caregiver #2 stated that Resident #2 was sometimes NJ Exec Order 26.4b1 about NJ Ex Order

Caregiver #3 stated that the last time she worked with Resident #2, the resident was observed NJ Exec Order 26.4b1, and when the caregiver asked the resident why he/she was NJ Exec Order 2 the resident stated that he/she NJ Exec Order 26.4b1. Caregiver #3 stated that she asked the nurse on duty to check on the resident.

At 12:25 p.m., the surveyor interviewed the Concierge to inquire what the protocol was after hours when concierge staff were not present at the facility. The Concierge stated that the night shift concierge staff person would lock the front doors and give the nurse on duty the concierge phone before leaving. The surveyor then inquired how Resident #2 was able to NJ Exec Order 26.4b1 if the NJ Ex Order 26.4(b)(1) were NJ Ex Order 26.4(and the Concierge stated that the NJ Ex Order 26.4(b)(1) were able to be NJ Ex Order 26.4(b)(1), however, the NJ Ex Order 2 were not able to be NJ Ex Order 26.4(b)(1). The surveyor inquired if staff would be alerted if the front doors opened after hours, and the Concierge stated that if the front doors opened after 11:00 p.m., the security system would send an alert to all staff phones and the concierge computer.

At 12:37 p.m. and 1:06 p.m., the surveyor conducted phone interviews with Caregiver #4 and Caregiver #5, who were on duty when Resident #2 NJ Exec Order 26 from the facility, to inquire about the previously mentioned NJ Exec Order 26.4b1

Caregiver #4 stated that her shift started at 11:00

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p.m., and that the facility was informed around 1:00 a.m. by the [redacted] that Resident #2 [redacted]" The surveyor inquired if the caregiver saw Resident #2 before the resident [redacted]" Caregiver #4 stated that she did not see Resident #2 on [redacted] and that she assisted "a lot" of residents who pressed their NJ Exec Order 26.4b1 for assistance with [redacted] once she started her shift. The surveyor inquired how often caregivers checked on residents, and Caregiver #4 stated that staff checked on residents every two hours. The surveyor inquired which caregiver was assigned to Resident #2, and the caregiver stated that Resident #2 was assigned to Caregiver #5. Caregiver #4 then stated that "everyone" knew Resident #2 was [redacted] including the nurses. Caregiver #4 also stated that the nurses stated that Resident #2 was NJ Exec Order 26.4b1 [redacted], and that he/she should be transitioned to NJ Exec Order 26.4b1). The surveyor inquired if the caregiver received a NJ Exec Order 26.4b1 that indicated that the [redacted] and Caregiver #4 stated that the phone sent an [redacted] about the [redacted], but she was assisting residents and did not hear it. Caregiver #4 stated that staff had no idea Resident #2 [redacted] from the facility until [redacted] called and informed them. The surveyor inquired how Resident #2 was able to NJ Exec Order 26.4b1, and Caregiver #4 stated that the [redacted] could be NJ Exec Order 26.4b1 and that no one sat at the NJ Exec Order 26.4b1

During surveyor's interview Caregiver #5, she stated that she arrived at the facility at 11:00 p.m. and made rounds. Caregiver #5 then stated that three residents pressed their NJ Exec Order 26.4b1 at the same time. Caregiver #5 explained that caregivers would answer the NJ Exec Order 26.4b1 together because something happened

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previously, and caregivers were "scared" to answer the NJ Exec Order 26.4b1 without a second caregiver present. The surveyor inquired when the caregiver found out that Resident #2 NJ Exec Order 26 from the facility. Caregiver #5 stated that she saw NJ Exec Order 26.4b1, and the NJ Exec Order stated that Resident #2 was NJ Exec Order 26.4b Caregiver #5 stated that NJ Exec Order then spoke to the nurse. The surveyor inquired which caregiver was assigned to Resident #2, and the caregiver stated that Caregiver #4 was assigned to Resident #2. The surveyor inquired how often the caregivers checked on residents, and Caregiver #5 stated that caregivers checked on residents on arrival and that some residents were NJ Exec Order 26.4b on every NJ Exec Order 26.4b1 while other residents did not like to be NJ Exec Order 26.4b1.

Additionally, Caregiver #5 explained that caregivers were notified of residents who required monitoring, such as residents at risk for NJ Exec Or Caregiver #5 stated that no one informed her that Resident #2 required NJ Exec Order 26.4b1. Caregiver #5 stated that Resident #2 was NJ Exec Order 26.4b1 and that the resident NJ Exec Order 2 . The surveyor inquired if the caregiver received an NJ Exec O that the NJ Exec Order 26.4b1, and Caregiver #5 stated that she did not. The surveyor inquired what the protocol was if an NJ Exec Order 26.4b1 was received. Caregiver #5 stated that the protocol was to check the door. Caregiver #5 also stated that an NJ Exec Order 26.4b1, and that the facility installed an NJ Exec Orde after Resident #2 NJ Exec Order 26.

The surveyor reviewed a document provided by the ED, which revealed that the NJ Exec Order 26.4b1 at 12:36 a.m.

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A 357	Continued From page 9 At 1:05 p.m., the surveyor attempted to conduct a phone interview with the LPN who was on duty at the time of the [NJ Exec Order 26.4b1] however, the LPN refused the interview. The surveyor reviewed the 7/29/2024 facility policy titled, "Change in Resident Condition," which indicated, "POLICY: When a resident exhibits a change in condition, action will be taken to coordinate safe and appropriate care and interventions. PROCEDURE: 1. All team members are trained to recognize changes in a resident's condition ... 3. Examples of change in condition may include, but not limited to ... g. Decline in cognitive function ..." In addition, the surveyor reviewed the 11/28/2023 facility policy titled, "Elopement/Missing Resident," which indicated, "POLICY: The community will ensure residents who are at risk for elopement are identified and that proper interventions are implemented to minimize elopement opportunities ... IDENTIFICATION & INTERVENTION PROCEDURES: ... 3. The resident's service plan will identify if the resident is determined to be at risk for elopement and interventions to minimize risk will be included in the service plan ... 6. The frequency and responsibility for monitoring the resident's location will be identified in the service/support plan ...." The facility did not ensure immediate and appropriate interventions were initiated and implemented when Resident #2 exhibited [NJ Exec Order 26.4b1] . The facility failed to provide Resident #2 the level of care he/she needed, including when his/her [NJ Exec Order 26.4b1] and other condition changed.	A 357		

BRANDYWINE by MONARCH COMMUNITIES

Plan of Correction

Brandywine at Livingston by Monarch Communities

369 E Mount Pleasant Avenue, Livingston, NJ 07039

License Number: 07A021

Inspection date: May 29, 2025

Signed by: [redacted] **Executive Director, CALA**

Submission Date: 7/18/2025

A 357 8:36-4.1 (a)(2) Resident Rights

Target Completion Date: January 18, 2026

1. Resident #2 was affected by this deficient practice. Resident #2 [redacted] An audible alarm was installed on exit doors on May 9th, 2025, as another indicator of the door being opened. Alarms are engaged from 11pm to 7:30am. At all other times, the front door is monitored by staff at the concierge desk.

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

3. All team members received in-service training on the following topics:

Resident Rights: July 9th, 2025
Resident Call System: July 10th, 2025
Change in Resident Condition: May 8th, 2025, July 9th, 2025
Elopement/Missing Resident: May 12th, 13th 14th, 2025; June 30th, 2025

All In-services were conducted by [redacted] Any staff not captured by the second-round of training ending on July 17th, 2025, will be individually re-educated on these topics prior to the start of his/her next shift.

Regional nursing staff conducted full audit reviews of all residents' charts from May 12th through May 14th, 2025. Regional nursing staff also conducted staff interviews regarding residents' conditions at that time. Based upon the results of the chart reviews and interviews, any resident identified as being at risk for elopement have been transitioned into memory care following

family and resident care plan discussions. All such resident care plans have been appropriately updated.

Residents attended a Resident Council meeting on July 16th, 2025, during which Resident Rights were read and distributed. For residents who were unable to attend, the Resident Rights were hand-delivered along with an explanation of each right. Family members of memory care residents received a copy of the Residents Rights via email.

4. The Life Enrichment Director (LED) or designee, will be responsible for ensuring that the Resident Rights are read at the Resident Council Meeting each month. The Executive Director (ED) or designee will monitor the Resident Council Meeting for the first 3 months and document compliance. This compliance will be reported at the next following Quality Assurance Meeting scheduled July 24th, 2025.

Additionally, the ED or designee will be responsible for ensuring that team members receive monthly Resident Rights training for the next 3 months. Documentation of this re-education will be maintained and presented at the next following Quality Assurance Meeting scheduled for July 24th, 2025. Annual re-education on Resident Rights will continue per normal routine in the facility.

The Wellness Director (WD) or designee will be responsible for monitoring the resident call system's response time. WD or designee will audit all resident call system's response times and document review on a weekly basis, including identifying of any shifts or staff member for which response times are lagging, and review this audit with the ED on a weekly basis. If a call remains unanswered for 10 minutes, the system will automatically notify both the WD and ED by text message to their personal cell phones. Any staff or shifts which are identified as routinely lagging in response times will receive immediate re-education by the WD or designee prior to the start of the next shift, with appropriate documentation. The formal audit and review of response times will continue for the next 4 months and will be presented at each Quality Assurance Meeting scheduled during that period.

The WD or designee will be responsible for reporting any changes in resident conditions. The ED or designee will monitor this process for 4 weeks, and then monthly thereafter for the following 3 months. Two months from today, Senior or Regional nursing with oversight to this facility will conduct a random audit of no less than 30% of residents' charts, including potential staff interviews if needed, regarding change in residents' conditions and documentation and care planning for same. The ED monitoring of changes in conditions and the Senior/Regional nursing audit will be presented at the following two Quality Assurance Meetings scheduled at two separate times on July 24th, 2025.

The Environmental Services Director (EVS) or designee will be responsible for conducting a monthly Elopement Drill for the following six months. In this six-month period, at least two of the

drills will be conducted during the nightshift and at least one will be conducted during a weekend shift. The results of each Elopement Drill will be presented to the ED within a day following the drill. These results will be reviewed at the Quality Assurance Meetings during this six-month period.

NJ Exec Order 26.4b1

accepted
8/1/25

Respectfully submitted,

NJ Exec Order 26.4b1

Executive Director
Brandywine at Livingston

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
07A021	A. Building B. Wing	8/1/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT LIVINGSTON	369 EAST MT PLEASANT AVENUE LIVINGSTON, NJ 07039

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 A0357 Reg. # 8:36-4.1(a)(2) LSC	Correction Completed 08/01/2025	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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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 5/29/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
07A021	A. Building B. Wing	8/1/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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