State of New Jersey
DEPARTMENT OF HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES
PO BOX 360
TRENTON, N.J. 08625-0360
www.nj.gov/health

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

KAITLAN BASTON, MD, MSc, DFASAM
Acting Commissioner

In Re Licensure Violation	:	NOTICE OF ASSESSMENT OF
Brandywine Living at Mountain Ridge	:	PENALTIES
(NJ Facility ID# NJ80A005)	:	

TO: Marie Milano, Administrator
Brandywine Living at Mountain Ridge
680 Mountain Boulevard
Watchung, NJ 07069

The Health Care Facilities Planning Act (N.J.S.A. 26:2H-1 et seq.) (the Act) provides a statutory scheme designed to ensure that all health care facilities are of the highest quality. Pursuant to the Act and N.J.A.C. 8:43E-1.1 et seq., General Licensure Procedures and Standards Applicable to All Licensed Facilities, the Commissioner of the Department of Health (the "Department") is authorized to inspect all health care facilities and to enforce the Standards for Licensure of Assisted Living Facilities set forth at N.J.A.C. 8:36-1.1 et seq.

LICENSURE VIOLATIONS & MONETARY PENALTIES:

Staff from the Department (Department) visited Brandywine Living at Mountain Ridge ("the facility" or "Brandywine") on March 27, 2023, for the purpose of conducting a complaint survey. The report of this visit, which is incorporated herein by reference, revealed that the facility failed to monitor and address the needs of a resident who was found intoxicated in their car. In addition, the facility failed to provide medical and psychosocial interventions to address the resident's depression and anxiety.

I. The facility failed to address the medical needs of a highly intoxicated resident.

On March 2, 2023, at approximately 11:00pm Resident #2 was found in their car with a whiskey bottle, with roughly a quarter of the whiskey remaining. The resident was brought to their room in a wheelchair and a registered nurse (RN #1) documented the following vital signs; blood pressure 92/60; oxygen level 85% and respiration 15. RN #1 documented that the resident showed signs of

gagging, which could lead to vomiting or aspiration, and positioned the resident sideways in bed with their head elevated 30 degrees to avoid aspiration. RN #1 explained that she shook the resident and called the resident by name, but the resident only responded to a "painful sternum rub." She confirmed that she did not notify the physician or send the resident to the emergency room (ER) for evaluation because she thought the resident was drunk and would sleep it off.

A licensed practical nurse (LPN #1) checked on the resident at 3:00 a.m., and at 6:30 a.m., and took the resident's vital signs which included a BP reading of 77/51. The LPN #1 did not notify the physician or an RN of the low BP, nor did she send the resident to the ER for evaluation. RN #3 received a report at 8:00 am from LPN #2 that Resident #2 was "drunk" and sleeping and was "fine." RN #3 stated that she read the resident's report and was concerned and immediately went to assess the resident. RN #3 stated that the resident was observed in a supine position, unresponsive, their BP was 66/40 and the resident was in a "grave situation." She immediately initiated a 911 call to transfer the resident to the ER for further evaluation. RN #3 confirmed that she was not notified of Resident #2's condition prior to arriving to work the morning of March 3, 2023.

The resident was admitted to the hospital with bilateral aspiration pneumonia and remained on a ventilator and unresponsive. On March 4, 2023, at 1:15 p.m., the resident expired at the hospital. The March 9, 2023, "Response to questions," which was faxed to the Department, indicated: "Resident's physician reached on 3/8 to determine official cause of death as acute respiratory failure due to bilateral aspiration pneumonia, acute metabolic hypoxia, hypoxic respiratory failure, alcohol intoxication and septic shock."

The facility failed to notify the physician of Resident #2's change in condition, failed to notify the RN, failed to follow its policy on "Emergency Transfer of Residents to Acute Care Facility NJ", and failed to ensure Resident #2 was provided the appropriate medical interventions to address the resident's change in condition, which began when the resident was observed in his/her car in the parking lot intoxicated with alcohol at 11:00pm on March 2, 2023, and continued for ten and half hours until 8:30am, on March 3, 2023, when the facility initiated a 911 call to transfer the resident to the emergency room.

These violations resulted in the failure of Resident #2 to receive necessary medical interventions related to their alcohol intoxication. As a result, Resident #2 was transferred to the hospital on March 3, 2023, having been found to be unresponsive, and later expired on March 4, 2023. The facility is in violation of N.J.A.C. 8:36-3.4(a)(1), N.J.A.C. 8:36-7.5(c), and N.J.A.C. 8:36-7.5(d). In particular:

- The facility failed to follow their emergency transfer policy and transfer Resident #2 to an acute medical facility in violation of N.J.A.C. 8:36-3.4(a)(1).
- The facility failed to notify the registered professional nurse in violation of N.J.A.C. 8:36-7.5(c).
- The facility failed to notify the physician of a resident's change in condition in violation of N.J.A.C. 8:36-7.5(d).

N.J.A.C. 8:43E-3.4(a)(10), allows the Department to impose a monetary penalty of $2,500 for violations resulting in either actual harm to a patient or resident, or in an immediate and serious risk of harm, which may be assessed for each day noncompliance is found.

In accordance with N.J.A.C. 8:43E-3.4(a)(10), and because the deficiencies resulted in actual harm to a resident, a $2,500 penalty is assessed for each of the three violations for the two days of noncompliance on March 2, 2023, and March 3, 2023, for a total of $15,000.

II. The facility failed to provide psychosocial interventions to address the resident's depression and anxiety.

Based on interview and record review, it was determined that the facility failed to revise and update the General Service Plan (GSP) with interventions to address the resident's psychosocial needs. On March 27, 2023, the surveyor reviewed Resident #2's closed medical record, and according to the "Resident Information," the resident's move-in date was August 16, 2022, and diagnoses included depression, anxiety, and Parkinson's disease. In addition, the psychiatric consult dated August 24, 2022 indicated that the resident was evaluated via telehealth due to history of depression and anxiety. The psychiatrist documented the following: "Moved in facility 1 week ago with ...[spouse]. Overwhelmed with caring for ... [spouse], worries about future... Sleep is poor at times." The psychiatrist also documented that the resident was prescribed Remeron 7.5 mg [milligrams] for depression/anxiety and to monitor mood and behavior, report changes to psychiatry and continue to engage in group/unit activities. In addition, the psychiatrist noted that the "[c]ase was discussed with team in collaboration."

Resident #2's September 7, 2022, psychiatric consult, revealed, "Reports mood is 'up and down.' Reports anxiety/worry 'everyday worry.' Sleep, reports get 4-6 hours at night, reports sleep is interrupted when making sure ... [spouse] is okay." The psychiatrist documented to continue to engage the resident in group/unit activities, monitor mood/behaviors, and address stressors as they arise.

The October 5, 2022, psychiatric consult, indicated, "Reports mood is 'lousy.' Reports periods of low mood-having a hard time adjusting to ALF [Assisted Living Facility] move. Reports anxiety/worry 'a little' about ...[spouse], reports sleep is interrupted when making sure ... [spouse] is okay."

The December 21, 2022, psychiatric consult revealed, "Reports periods of low mood 'there are days when I feel down and other days, I feel good."

The March 1, 2023, psychiatric consult, specified, "Reports enjoys walking 'It's my meditation.' Reports periods of low mood, sadness, feeling depressed. Reports periods of anxiety/worry. Verbalized caring for ...[spouse] can at times be stressful for him/her."

The surveyor reviewed Resident #2's February 3, 2023, Care Plan (CP), provided by the Wellness Director (WD). The surveyor found that there was no documented evidence that the resident's CP had been revised with interventions to address the resident's depression and anxiety after the resident was seen by the psychiatrist on August 24, 2022, September 7, 2023, October 5, 2023, December 21, 2022, and March 1, 2023. On March 28, 2023, at 12:55 p.m., the surveyor interviewed the WD regarding Resident'#2's CP following the psychiatrist consults. The WD acknowledged that the CP was not updated with interventions.

The surveyor asked the WD if the resident had been intoxicated before at the facility and she said "No." The WD added that, according to the resident's daughter, the resident had a history of alcohol consumption and last drank 30 to 40 years ago. Further, the WD explained that the resident resided in the same apartment with the spouse and that the resident had difficulty adjusting to the spouse's

decline in health, and they verbalized that "caring for ...[spouse] can at times be stressful for him/her."

The facility failed to ensure that Resident #2 was provided medical and psychosocial interventions in violation of N.J.A.C. 8:36-4.1(a)(2) – Resident Rights - Survey Tag A-357. These violations resulted in the failure of Resident #2 to receive necessary psychosocial interventions to address their depression and anxiety, which culminated in Resident #2's incident of alcohol intoxication on March 2, 2023.

N.J.A.C. 8:43E-3.4(a)(8) allows the Department to impose a monetary penalty of $1,000 per violation for each day noncompliance is found for multiple deficiencies related to patient care or physical plant standards throughout a facility, and/or where such violations represent a direct risk that a patient's physical or mental health will be compromised, or where an actual violation of a resident's or patient's rights is found.

In accordance with N.J.A.C. 8:43E-3.4(a)(8), the violations were related to patient care and represented a direct risk to the patient's physical health, therefore $1,000 per violation is assessed for each day noncompliance is found. On October 5, 2022, the resident had a psychiatric consult and reported having periods of low mood, having a hard time adjusting to assisted living facility, and having anxiety/worrying about their spouse. This consult went unaddressed, as evidenced by a failure to update the residents care plan, through March 4, 2023, the date the resident expired. This violation persisted for a total of 149 days for a penalty amounting to $149,000.

Therefore, in accordance with N.J.A.C. 8:43E-3.4(a)(10) and N.J.A.C. 8:43E-3.4(a)(8), and because such violations resulted in actual harm or represented a direct risk to a resident's health, the total penalty assessed is $164,000.

The total amount of this penalty is required to be paid within 30 days of receipt of this letter by certified check or money order made payable to the "Treasurer of the State of New Jersey" and forwarded to Office of Program Compliance, New Jersey Department of Health, P.O. Box 358, Trenton, New Jersey 08625-0358, Attention: Lisa King. **On all future correspondence related to this Notice, please refer to Control X23012.**

INFORMAL DISPUTE RESOLUTION (IDR):

N.J.A.C. 8:43E-2.3 provides facilities with the option to challenge factual survey findings by requesting Informal Dispute Resolution with Department representatives. Facilities wishing to challenge only the assessment of penalties are not entitled to IDR review, but such facilities may request a formal hearing at the Office of Administrative Law as set forth herein below. IDR requests **must be made in writing within ten (10) business days from receipt of this letter** and must state whether the Facility opts for a telephone conference, or review of Facility documentation only. The request must include an original and ten (10) copies of the following:

- The written survey findings;
- A list of each specific deficiency the facility is contesting;
- A specific explanation of why each contested deficiency should be removed; and
- Any relevant supporting documentation.

Any supporting documentation or other papers submitted later than 10 business days prior to the scheduled IDR may not be considered at the discretion of the IDR panel.

FORMAL HEARING:

Brandywine at Mountain Ridge is entitled to a formal hearing at the Office of Administrative Law (OAL) to challenge this assessment of penalties pursuant to N.J.S.A. 26:2H-13. Brandywine at Mountain Ridge may request a hearing to challenge the assessment of penalties. Brandywine at Mountain Ridge must advise this Department within 30 days of receipt of this letter if it requests an OAL hearing regarding this matter.

Please forward your OAL hearing request to:

Attention: OAL Hearing Requests
Office of Legal and Regulatory Compliance
New Jersey Department of Health
P.O. Box 360
Trenton, New Jersey 08625-0360

Corporations are not permitted to represent themselves in OAL proceedings. Therefore, if Brandywine at Mountain Ridge is owned by a corporation, representation by counsel is required by law.

In the event of an OAL hearing regarding this matter, Brandywine at Mountain Ridge is further required to submit a written response to every charge specified in this Notice, which shall accompany your written request for a hearing.

In accordance with N.J.A.C. 8:43E-3.5(c)(1), failure to submit a written request for a hearing within 30 days from the date of receipt of this notice will render this a final agency decision assessing the amount of the penalty, which shall then become due and owing. Further, at the request of the Department, the Clerk of the Superior Court or the Clerk of the Superior Court, Law Division, Special Civil Part, shall record the final order assessing the penalty on the judgment docket of the court, in accordance with N.J.S.A. 2A:58-10. The final agency decision shall thereafter have the same effect as a judgment of the court.

Be advised that Department staff will monitor facility compliance with this Notice to determine whether corrective measures are implemented by the facility and whether assessed penalties are paid in a timely fashion. Failure to comply with these and any other applicable requirements, as set forth in pertinent rules and regulations, may result in the imposition of additional penalties.

Sincerely,

Lisa King, Program Manager
Office of Program Compliance
Division of Certificate of Need & Licensing

LK:mt
DATE: January 17, 2024
REGULAR AND
CERTIFIED MAIL:
RETURN RECEIPT REQUEST
Control # X23012