STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LHR4HN	A. BUILDING: _____ B. WING _____	C 10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT PRINCETON	155 RAYMOND ROAD PRINCETON, NJ 08540

(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 #: NJ00188894 Census:101 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 310	8:36-3.4(a)(1) Administrator's Responsibilities (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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint#: NJ00188894

Based on interview and record review, it was determined that the Executive Director (ED) failed to ensure effective oversight of staffing, supervision, safety operations and a thorough incident investigation in the NJ Exec Order 26.4b1 unit through enforcement of the facility policies and procedures, including conducting a thorough investigation of the incident in the NJ Ex Order 26.4(b)(1) unit for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On NJ Exec Order 26.4b1, the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE) regarding the elopement of Resident #2. According to the FRE, at approximately 1:00 p.m., Resident #2 NJ Exec Order the NJ Exec Order 26.4b1 and NJ Exe the NJ Exec Order 26.4b1. The FRE indicated that Resident #2 was NJ Exec Order 26.4b1 by a private duty aide NJ Exec Order 26 the NJ Exec Order 26.4 and was NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 unit. The FRE further documented that Resident #2 resided on a NJ Exec Order 26.4b1 requiring a NJ Ex Order 26.4(b)(1), and that Resident #2 NJ Exec Order 26.4b1 through an NJ Exec Order 26.4b1. Resident #2 was NJ Exec Orde approximately NJ Exec Order 26.4b1 from the community.

On October 7, 2025, at 12:10 p.m., the surveyor interviewed the ED. The ED stated that

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A 310	Continued From page 2	A 310		

construction workers had been provided the NJ Exec Order 26.4b1 unit by the Maintenance Director and that the NJ Ex Order 26.4(b)(1) had been turned off to allow vendors access. The ED stated that the facility did not conduct routine rounds and that residents were checked only twice per shift. When questioned regarding staffing and break coverage, the ED stated that he was not familiar with staff break schedules and that scheduling oversight was the responsibility of the Health and Wellness Director (HWD). The ED confirmed he was unaware that multiple staff members had been off the unit at the same time during the incident and that he had not reviewed staffing coverage as part of the investigation.

At 2:25 p.m., the surveyor interviewed the HWD regarding staffing and break coverage. The HWD stated that staff coordinated their own breaks with the Licensed Practical Nurse (LPN), that she did not monitor or verify break times, and that she was unaware that multiple staff were on break simultaneously. The HWD confirmed that she did not review staffing coverage for the date of the incident.

At the time of the survey, the LPN Supervisor was not available for interview.

Surveyor review of a facility schedule dated Tuesday, September 30, revealed that a NJ Exec Order 26.4b Life Enrichment Coordinator (LEC) was scheduled to work on the day of the incident.

At 11:25 a.m., the surveyor interviewed the LEC who was scheduled on the date of the incident. The LEC stated that she had called out and was not working that day and stated that she believed Resident #2 may have NJ Exec Order 26.4b1

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A 310	Continued From page 3 NJ Exec Order 26.4b1 . Surveyor review of an undated facility document titled, "Employee Timesheet," revealed that Staff #2 and the LPN were noted to be on break at the same time on the date of the incident. Further surveyor review determined that a thorough investigation was not completed. The Executive Director (ED) did not review the Incident Investigation Report for accuracy, did not reconcile inconsistencies in staff statements regarding the time Resident #2 was last observed on the NJ Exec Order 26.4b1), and did not review the staffing assignment sheets, staff break logs or timecards to confirm which employees were present on the unit during the incident. This lack of investigative oversight prevented the identification of staffing gaps and contributed to the failure to determine how and when Resident #2 NJ Exec Order 26.4b1. Surveyor review of a last revised 1/1/2021, facility policy titled, "Staffing," revealed: "Policy: The community will provide adequate staffing to respond promptly and effectively to residents' needs while providing quality care and services..." Surveyor review of a revised 11/28/2023 facility policy titled, "Elopement/Missing Resident" revealed: "Door alarms will not be disabled without being continuously monitored by an assigned team member..." Surveyor review of a revised 7/24/23 facility policy titled, "Resident Incident Reports" revealed: "...Procedure...8.The ED and HWD are responsible for ensuring that state specific reporting requirements are reviewed...Timely and accurate reporting to state specific agencies will	A 310		

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A 310	Continued From page 4 occur as required by state regulations..."	A 310		
A 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider shall 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: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188894 Based on interview and record review, it was determined that the facility failed to ensure a safe environment when 1 of 3 residents reviewed when Resident #2, NJ Exec Order 2 from the NJ Exec Order 26.4b1 [redacted]. This deficient practice was evidenced by the following: On NJ Exec Order 26.4b1 the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE) regarding the NJ Exec Order 26.4b1 of Resident #2. According to the FRE, at approximately 1:00 p.m., Resident #2 NJ Exec Order the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The resident was later observed by a private duty aide	A 401		

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A 401	Continued From page 5	A 401		

NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 to the NJ Exec Order. The FRE documented that Resident #2 resided on a NJ Exec Order 26.4b1 requiring a NJ Exec Order 26 and that Resident #2 had NJ Exec Order through an NJ Exec Order 26.4b1. Resident #2 was NJ Ex Order 2 approximately NJ Exec Order 26.4b1 from the NJ Exec Order 26.4b1

On October 7, 2025, at 10:00 a.m., the surveyor interviewed the Executive Director (ED), who confirmed the information documented in the facility's FRE submitted to the Department. The ED provided the surveyor with a copy of the facility's Incident Investigation Report for review.

Surveyor review of the facility's "Incident Investigation Report" dated NJ Exec Order 26, submitted by the ED, revealed that the report contained a summary and conclusion of the circumstances of Resident #2's NJ Exec Order 26.4b1 The investigation stated that Resident #2 was NJ Exec Order 26.4b1 in the NJ Exec Orde between 11:30 a.m. and 12:00 p.m. during lunch and had NJ Exec Order the NJ Exec Order 26.4b1 by NJ Exec Order 26.4b1 an individual NJ Exec Order 26.4b1. The report indicated that no staff witnessed Resident #2 NJ Exec Order 26 the NJ Exec Orde or the NJ Exec Order 26.4b1 Resident #2 was later observed NJ Exec Order 26.4b1 by a private duty aide and NJ Exec Order 26.4b1 . The investigation documented Resident #2 resided in a NJ Exec Order 26.4b1 that required a NJ Exec Order 26 that the NJ Exec Order 26.4b1 had been NJ Exec Order 26.4b1 . The investigation further noted that upon the Resident #2's return, the clinical team completed a comprehensive assessment and Resident #2 was evaluated by the facility physician. The report also indicated that the facility completed a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and a staff resident rights in-service following the incident.

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A 401	Continued From page 6 Surveyor review of the Medical Record for Resident #2 revealed that Resident #2 was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1 [redacted] At 10:10 a.m., the surveyor observed Resident #2 seated in the television room. Resident #2 was unable to be interviewed due to NJ Exec Order 26.4b1 [redacted] At 11:10 a.m., the surveyor interviewed Staff #2, a CHHA hired on NJ Exec Order 26.4b1. Staff #2 stated that as she was leaving the building, she observed Resident #2 NJ Exec Order 26.4b1, NJ Exec Order 2 Resident #2 NJ Exec Order 26.4b1, and NJ Exec Order 26.4b Resident #2 to the NJ Exec Order 26.4b1. She stated that she had NJ Exec Order 26.4b1 Resident #2 at approximately 11:30 a.m. during lunch, left for break at 12:15 p.m., and again NJ Ex Order 26.4(b)(1) Resident #2 NJ Exec Order 26.4b1 1:00 p.m. as she was leaving to go home. At 11:30 a.m., the surveyor interviewed Staff #1, a CHHA hired on NJ Exec Order 26.4b1. Staff #1 stated that she believed Resident #2 NJ Exec Order 26.4b1 while staff were cleaning up from lunch. She reported that she and Staff #3 were the only staff on the unit at that time and would not have seen Resident #2 NJ Exec O Staff #1 stated that she was unsure if the Licensed Practical Nurse (LPN) had been present on the unit and believed the LPN may have been in the medication room. Staff #1 also stated that two Life Enrichment Assistants (LEA) staff had gone on lunch break together, leaving only two staff on the unit. At 1:15 p.m., the surveyor interviewed Staff #3, a CHHA hired on NJ Exec Order 26.4b1. Staff #3 stated that	A 401		

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A 401	Continued From page 7	A 401		

she and Staff #1 had been cleaning up after lunch and were unaware that Resident #2 had [NJ Exec Order 26.4b1] the [NJ Exec Order 26.4b1] unit and stated that the LPN had been downstairs at the time. She stated that Resident #2 had [NJ Exec Order 26.4b1] by LEA staff at approximately 12:35 p.m., was [NJ Exec Order 26.4b1] to the [NJ Exec Order 26.4b1] around 1:05 p.m., and that although she remembered Resident #2 near [NJ Ex Order 26.4(b)(1)] earlier, she did [NJ Exec Order 26.] Resident #2 [NJ Exec O]

At 12:10 p.m., the surveyor re-interviewed the ED. The ED stated that Resident #2 had last been seen between 11:30 a.m. and 12:00 p.m. during lunch and was [NJ Ex Order 26.4(b)(1)] at approximately 1:20 p.m. The ED confirmed that construction workers had been provided the [NJ Exec Order 26.4b1] by the Maintenance Director and that the [NJ Exec Order 26.4b1] had been [NJ Exec Order 26(NJ Ex] and the [NJ Ex Orde] had been [NJ Ex Order 26.4(b)(1)] for vendor access. The ED stated that rounds were not routinely conducted and that residents were checked only twice per shift. The ED also stated that he was not familiar with the staff break schedules and that the Health and Wellness Director (HWD) was responsible for scheduling.

At 2:25 p.m., the surveyor interviewed the HWD, who stated that staff coordinated their own breaks and that she did not monitor or verify when staff breaks occurred.

Surveyor review of the revised 1/1/2021, facility policy titled, "Staffing" indicated:
"Policy: The community will provide adequate staffing to respond promptly and effectively to residents' needs while providing quality care and services ..."

Surveyor review of the revised 11/28/2023, facility

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A 401	Continued From page 8 policy titled, "Elopement/Missing Resident" revealed the following: "Policy: ... Identification & Intervention Procedures ... 9. Door alarms will not be disabled without being continuously monitored by an assigned team member ..."	A 401		
A 537	8:36-5.7(a)(1) Policy and Procedure Manual (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following: 1. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and resident care services of the facility or program; This REQUIREMENT is not met as evidenced by: Complaint#: NJ00188894 Based on observation and record review, it was determined that the facility failed to maintain its policies and procedures in accordance with N.J.A.C. 8:36-5.7, which required that all policies	A 537		

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A 537	Continued From page 9	A 537		

be reviewed at least annually and that such review be documented. This deficient practice was evidenced by the following:

On 10/7/25, the surveyor reviewed a facility policy titled, "Staffing," dated last revised 01/01/2021. The policy contained no written evidence that indicated that it had been reviewed or updated since the listed revision date.

The surveyor also reviewed a facility policy titled, "Resident Incident Reports," dated last revised 07/24/2023. There was no documentation showing that this policy had received an annual review or any subsequent updates.

Review of a facility policy titled, "Elopement/Missing Resident," dated last revised 11/28/2023, revealed no written documentation that demonstrated that it had been reviewed or updated after that date.

Additional policies provided by the Health and Wellness Director did not contain any documented evidence showing that the facility reviewed its policies at least annually. None of the policies reviewed included review dates, revision dates, administrative approval, or other documentation demonstrating that the policies were maintained and updated as required under N.J.A.C. 8:36-5.7.

BRANDYWINE

PRINCETON

PLAN OF CORRECTION -BRANDYWINE PRINCETON

Survey Date: 10/07/25

Complaint: NJ00188894

Facility: Brandywine Princeton

A310 – 8:36-3.4(a)(1) Administrator Responsibilities

The regulation requires the Administrator to ensure that all operational systems are functioning appropriately, staffing assignments are accurate, supervision is adequate, and policies are followed to protect resident health and safety.

During the survey, it was identified that certain operational processes – including supervision patterns, adherence to break coverage, environmental oversight, and vendor access controls – did not fully align with established policy expectations. These gaps resulted in a breakdown of the community's elopement-prevention system, prompting the citation under Administrator Responsibilities.

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:

Resident #2, a NJ Exec Order 26.4b1 esident residing at Brandywine Living at Princeton NJ Exec Order 26.4b1 rom the NJ Exec Order 26.4b1 and was immediately NJ Exec Order 26.4b1 to the community on NJ Exec Order 26.4b1, the same day as the NJ Exec Order 26.4b1 Upon return, the RN Director of Health & Wellness completed a full nursing assessment on NJ Exec Order 26.4b1 ncluding evaluation for NJ Exec Order 26.4b1 NJ Exec Order 26 The resident was subsequently NJ Exec Order 26.4b1 in accordance with community protocol. Resident #2 sustained NJ Exec Order 26.4b1 and experienced NJ Exec Order 26.4b1 related to the incident. The physician and responsible party were notified on NJ Exec Order 26.4b1 of the incident and updated assessment findings. The resident's service plan was revised by the RN, on NJ Exec Order 26.4b1 to reflect increased NJ Exec Order 26.4b1 measures.

In addition, all exit doors and alarm systems were inspected by the Executive Director to ensure proper functioning, and documentation of those environmental checks was completed. These corrective actions were initiated on 9/30/25 and fully completed on 10/3/25.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents residing in the Memory Care Unit were identified as having the potential to be affected by this deficient practice. Following the incident, a comprehensive review of all Memory Care residents was completed to reassess elopement risk levels and to ensure that each resident's service plan accurately reflected individualized supervision needs and interventions. This comprehensive review of current elopement risk, service plans, and supervision levels for all Memory Care residents was conducted by the RN Director of Health & Wellness, under the oversight of the Executive Director, initiated on 10/8/25 and completed on 10/15/25. In addition to the resident-level review, a community-wide environmental assessment was conducted by the Executive Director to verify that all door alarms, exit systems, and related safety mechanisms were functioning properly and that no environmental risk factors were present that could compromise resident safety. Executive Director, initiated on 10/8/25 and completed on 10/15/25.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

To prevent recurrence, multiple systemic changes were implemented. All staff received comprehensive in-service training on elopement prevention, supervision expectations, and emergency response procedures to reinforce consistent practice across all departments. Complete on 10/30/25 by the RN, DOW. The break coverage protocol was rewritten by the Executive Director on 10/17/25 to require supervisory assignment and sign-off before any staff member leaves their post, ensuring uninterrupted coverage in secured areas.

The Incident Investigation Form was redesigned by the Executive Director on 10/17 and implemented on 10/30/25 to include detailed root-cause analysis, environmental review, staffing verification, and required administrative sign-off to ensure thorough documentation and follow-through. The vendor escort policy was strengthened by the RN, DOW, 10/15/25 and implemented by 10/30/25 to prohibit unescorted access to secured units, and a vendor log was instituted to track compliance. Additionally, quarterly elopement drills were added to the safety calendar by the RN, DOW, on 10/15/25 and implemented on 10/30 to test response readiness and reinforce staff competency.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur:

Audits of break coverage logs, door alarm checklists, staffing assignment sheets, and vendor access logs were conducted by the RN, Dow, on 10/30/25, followed by monthly audits for the subsequent three (3) months. All findings from these audits were reviewed during the community's QAPI meetings, where any identified concerns were addressed promptly through corrective actions. All monitoring logs and audit tools will be retained for a minimum of one (1) year to provide documentation of sustained compliance and continued oversight. Initial monitoring was completed on 10/10/25, with quarterly reviews thereafter. Completion Date: 10/30/2025.

A401 – 8:36-4(a)(22) Resident Rights: Safe Environment

Residents have the right to live in a safe environment with appropriate protections, supervision, and functional safety systems such as alarms, secured exits, and environmental controls.

The survey findings indicated that the systems in place to ensure resident safety in the Memory Care Unit, including door alarm functioning, supervision expectations, and environmental monitoring processes, were not consistently implemented. This contributed to an unsafe condition in which a resident was able to exit the secure area without staff awareness, resulting in a citation under resident safety rights.

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:

Resident #2, a NJ Exec Order 26.4b1 esident residing at Brandywine Living at Princeton, was assessed immediately following the NJ Exec Order 26.4b1 he RN, Director of Health & Wellness, completed a comprehensive nursing assessment on NJ Exec Order 26.4b1 including evaluation for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 was identified. The resident's service plan was revised on NJ Exec Order 26.4b1 y the RN, to reflect NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 measures. The responsible party was notified on NJ Exec Order 26.4b1 of the incident, assessment findings, and plan of care updates. All NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) were tested and verified for proper functionality by the Executive Director on NJ Exec Order 26.4b1 with documentation completed.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents residing in the Memory Care Unit were identified as having the potential to be affected by this deficient practice. A comprehensive review of Memory Care residents' service plans, elopement risk levels, and supervision requirements was conducted by the RN, Director of Health & Wellness, under the oversight of the Executive Director. This review was initiated on 10/8/25 and completed on 10/16/25. Any necessary updates to supervision levels, safety checks, or elopement precautions were implemented and documented. In addition, on 10/17/25 the Executive Director conducted a full environmental assessment of the Memory Care Unit to verify that all secured exits, alarms, and access controls were functioning appropriately and posed no safety risk.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

To protect residents' rights to a safe environment and prevent recurrence, systemic changes were implemented. A Daily Memory Care Door and Alarm Check Log was established by the RN, DOW on 10/10/25 to ensure all exit doors, alarms, and secured access points are tested and documented each shift. In addition, the Registered Nurse (RN) established and implemented daily nursing alarm checks effective 10/10/25. Staffing assignment sheets were revised by the Executive Director on 10/17/25 to clearly define supervisory responsibility and coverage at all times. Vendor access and escort procedures were reinforced by the ED on 10/30 to prohibit unescorted access to secured areas. Leadership presence in the Memory Care Unit was increased during high-risk periods, including shift changes and meal transitions, to reinforce supervision expectations and provide real-time oversight. These systemic changes apply to all Memory Care residents, staff, and operational processes.

Re-education on resident rights, elopement risks awareness, alarm response expectations, and documentation standard was provided to Memory Care Staff by the RN, Director of Wellness, on 10/10/25, with attendance documented.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur:

The Executive Director or designee will review completed Door and Alarm Check Logs daily for the first thirty (30) days, weekly for the following sixty (60) days, and monthly thereafter for nine (9) months. Supervision assignments will be reviewed daily to ensure appropriate coverage. Implemented on

10/30/25. Audit, started on 10/10/25, results will be reviewed through the QAPI process with corrective action taken as needed. All monitoring documentation will be retained for a minimum of one (1) year. Completion Date: 10/30/2025.

A-0537-8:36-5.7(a)(1)-Policy and Procedures

This regulation requires all policies and procedures to be current, accurate, complete, and reflective of actual practice within the community.

Surveyors identified that several policies related to elopement prevention, supervision, environmental checks, and incident investigation were either outdated, not reflective of current systems, or not consistently implemented as written. This inconsistency between written policy and operational practice resulted in the citation for policy and procedure management.

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:

The Executive Director initiated a targeted review of policies related to elopement prevention, supervision, environmental safety, incident investigation, and vendor access on 10/9/25, with support from the RN, Director of Health & Wellness. All relevant policies were reviewed, updated, and revised to ensure accuracy, regulatory compliance, and alignment with actual practice within the community. Upon completion on 10/10/25, the Executive Director and the RN verified that all revised policies accurately reflected implemented systems and staff expectations. Updated policies were redistributed to staff for review on 10/17/25 and implemented.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice:

All residents were identified as having the potential to be affected by outdated or inconsistent policies. To ensure accuracy and consistency, the Executive Director initiated, on 10/10/25, a facility-wide policy and procedure review. Department Heads were responsible for reviewing policies within their respective service areas, including Nursing, Dining, Maintenance, Housekeeping, and Activities. This review was completed on 10/17/25 and ensured that all policies impacting resident care and safety were current and reflective of practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

To prevent recurrence, systemic controls were implemented. An Annual Policy and Procedure Review Schedule and Log was established requiring formal review and administrative sign-off of all policies at least annually. The Policy and Procedure Review Log was established by the RN on 10/10/25. Version-control measures were implemented on 10/10/25 and are maintained by administration to ensure that only current, approved policies are in circulation and outdated versions are removed from use. Department Heads received re-education from the Executive Director on 10/14/25 regarding policy access, review expectations, and dissemination responsibilities.

Completion Date: 10/17/2025.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur:

The Executive Director, or designee will conduct quarterly audits of the Policy and Procedure Review Log to ensure required reviews and signatures are completed. Random staff interviews were conducted by the Executive Director on 10/17/25 to verify awareness and implementation of revised policies, with particular focus on elopement prevention and resident safety. Audit results will be reviewed through QAPI, and corrective action will be taken as needed. Monitoring documentation will be retained for a minimum of one (1) year. The Executive Director completed the initial quarterly audit on 10/17/2025.

Completion Date: 10/17/2025.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
LHR4HN Y1	A. Building B. Wing Y2	1/23/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT PRINCETON	155 RAYMOND ROAD PRINCETON, NJ 08540

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 10/30/2025	ID Prefix A0401 Reg. # 8:36-4.1(a)(22) LSC	Correction Completed 10/30/2025	ID Prefix A0537 Reg. # 8:36-5.7(a)(1) LSC	Correction Completed 10/17/2025
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	
10/7/2025	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
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