STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10A002	A. BUILDING: _____ B. WING _____	C 10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING @ MOORESTOWN	1205 N. CHURCH STREET MOORESTOWN, NJ 08057

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Standard w/ Complaint COMPLAINT #: NJ00188818 CENSUS: 120 SAMPLE SIZE: 7 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 269	8:36-3.1(a) Administration (a) An administrator shall be appointed and an alternate shall be designated in writing to act in the absence of the administrator. The administrator or a designated alternate shall be available at all times and shall be on-site at the facility on a full-time basis in facilities that have 60 or more licensed beds, and on a half-time basis in facilities that have fewer than 60 licensed beds, in accordance with the definition of "full-time" and "half-time" at N.J.A.C. 8:36-1.3.	A 269		

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

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A 269	Continued From page 1	A 269		

This REQUIREMENT is not met as evidenced by:
Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that an alternate Executive Director (ED) was designated in writing which had the potential to affect all 120 residents that resided at the facility at the time of the survey. This deficient practice was evidenced by the following:

On 10/15/25 at 9:00 a.m., the surveyor arrived at the facility and requested the ED.

At 9:05 a.m., the Culinary Services Director (CSD) stated that the ED was absent and that the Director of Nursing (DON) was the alternate ED. The surveyor then requested to speak with the DON who was acting as the alternate ED, and the CSD stated that she was not present at the facility. The FSD explained that the DON was new and that she floated to multiple facilities for training. The surveyor then inquired who was acting in the ED's absence, if the DON was not present at the facility, and the CSD stated that he would make some phone calls.

At 9:15 a.m., during an interview with the facility's Float Registered Nurse (RN), the RN confirmed that the ED was absent.

At 9:22 a.m., the RN returned and stated that the ED was on his way to the facility.

At 9:28 a.m., the Director of Sales and Marketing (DSM) stated that she was the alternate ED.

The surveyor reviewed the DSM's employee file

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A 269	Continued From page 2 and was not able to locate a signed job description for alternate ED. In addition, the surveyor toured the facility and reviewed facility documents, however, the surveyor did not observe documentation or a posting that indicated who the alternate ED was. At 10:29 a.m., the surveyor observed the ED, who stated that he arrived at the facility at 10:00 a.m. At 3:46 p.m., during the exit conference, the surveyor interviewed the ED to inquire who the alternate ED was, and the ED stated that the DSM was the alternate ED. The surveyor then inquired the reason the alternate ED was not designated in writing, and the ED stated that he was not aware that it had to be written.	A 269		
A 310	8:36-3.4(a)(1) Administration (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; This REQUIREMENT is not met as evidenced	A 310		

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A 310	Continued From page 3 by: Based on interview and record review, it was determined that the Administrator failed to ensure the implementation and enforcement of the facility policy titled, "Medication Storage" for 2 of 7 residents, Resident #s 5 and 6. This deficient practice was evidenced by the following: 1. On 10/15/25 at 10:15 a.m., the surveyor reviewed Resident #5's medical record (MR), which revealed that Resident #5 was admitted to the facility in [redacted] of [redacted] with diagnoses of [redacted] NJ Exec Order 26.4b1 [redacted]). Further review of Resident #5's physician orders revealed that on [redacted], Resident #5 was ordered [redacted] NJ Exec Order 26.4b1 [redacted]) every six (6) hours as needed for [redacted] 2. At 10:16 a.m., the surveyor reviewed Resident #6's MR, which revealed that Resident #5 was admitted to the facility in [redacted] NJ Exec Order 26.4b1, with diagnoses of [redacted] Further review of Resident #6's physician orders revealed that on [redacted], Resident #6 was ordered [redacted] NJ Exec Order 26.4b1 every 12 hours as need for [redacted] At 12:22 p.m., the surveyor performed a medication [redacted] count with a Licensed Practical Nurse (LPN) on medication cart #1, which revealed the following: Resident #5's bingo card had a hole in the designated place for pill #20 and had tape securing pill #20 in place. Resident #6's bingo card had a hole in the	A 310		

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A 310	Continued From page 4 designated place for pill #14 and had tape securing pill #14 in place. The surveyor reviewed the facility policy and procedure dated for 3/21/2023 and titled, "Medication Storage" which revealed that " Procedure: ... 6. Medications that are ... without secure closures are immediately removed from the locked medication storage area and properly disposed of."	A 310		
A 355	8:36-4.1(a)(1) Resident Rights comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, 1. The right to receive personalized services and care in accordance with the resident's individualized general service and/or health service plan; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188818 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident received personalized services and care in accordance with the resident's individualized	A 355		

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A 355	Continued From page 5 General Service Plan (GSP) for 1 of 7 residents reviewed, Resident #3. This deficient practice was evidenced by the following: On 10/16/25 at 10:06 a.m., the surveyor interviewed Resident #3's NJ Exec Order 26.4 who shared an apartment with the resident. Resident #3's NJ Ex Order 26.4 stated that Resident #3 had a NJ Exec Order 26 , and that the resident has had NJ Ex O NJ Exec Or and a NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b and a NJ Exec O Resident #3's NJ Exec Order 26 stated that staff previously NJ Exec Order 26.4b1 Resident #3 NJ Ex Order and left the resident NJ Exec Order for long periods of time. Resident #3's NJ Exec Order 26 stated that he/she requested that staff provide Resident #3 with additional NJ Exec Order 26.4b1 care at 3:00 a.m. However, Resident #3's NJ Exec Order 26 stated that staff would not provide NJ Exec Order 26.4b1 care at 3:00 a.m., until after Ombudsman got involved. The surveyor reviewed the Medical Record (MR) of Resident #3, who was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses of NJ Ex Order 26.4(b)(1) and NJ Exec Order 26.4b1 The surveyor reviewed Resident #3's GSP dated NJ Exec Order 26. , which indicated, "Resident requires NJ Exec Order 26.4b1 with NJ Exec Order 26.4 ... NJ Exec Order 26.4b1 and requires staff NJ Exec Order 26.4b1 and/or NJ Exec Order 26.4 program. Care managers to assist with resident's NJ Exec Order 26.4b1 needs and ensure resident remains NJ Exec Order 26.4b1 " In addition, the surveyor reviewed Resident #3's "Physician Order Review," which revealed that the resident was prescribed NJ Exec Order 26.4b1 two times a day (used to treat and prevent NJ Exec Orde on NJ Exec Order 26.4b1 .	A 355		

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A 355	Continued From page 6 The surveyor reviewed the facility's policy titled, "Continence Care," revised on 1/1/21, which indicated, "POLICY: Residents will receive assistance with continence management as identified in the resident's service plan ... 6. The HWD [Health & Wellness Director] or designee reviews results to determine any pattern of resident's incontinent episodes. For example: a. Always incontinent after meals b. Incontinent episode every two (2) to three (3) hours c. Only incontinent at night ..." Additionally, the surveyor reviewed the facility's policy titled, "Resident Rights," revised on 6/2/22, which indicated, "POLICY: The community will operate in a manner that respects the personal dignity and human rights of each resident ..."	A 355		
A 517	8:36-5.6(b)(1-7) General Requirements (b) The facility or program shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following: 1. The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment; 2. Emergency plans and procedures; 3. The infection prevention and control program;	A 517		

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A 517	Continued From page 7 4. Resident rights; 5. Abuse and neglect; 6. Pain management; 7. The care of residents with Alzheimer's and related dementia conditions and in accordance with N.J.A.C. 8:36-19. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that 9 of 9 staff members, whose personnel records were reviewed, received the required annual staff education. This deficient practice was evidenced by the following: On 10/16/25 at 9:57 a.m., the surveyor reviewed personnel files, which revealed the following: 1. Employee #1, a Community Operations Manager was hired on [redacted] The file did not	A 517		

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A 517	Continued From page 8 contain documented evidence that the employee received orientation at the start of employment and completed the annual in-service education on emergency drills, assisted living concepts, resident rights, infection control, abuse and neglect, emergency training, Alzheimer dementia, and pain management. 2. Employee #2, a Line Chef was hired on [NJ Exec Order]. The file did not contain documented evidence that the employee received orientation at the start of employment. Additionally, the annual in-service education was not current on emergency drills, assisted living concepts, resident rights, infection control, abuse and neglect, emergency training, Alzheimer dementia, and pain management. 3. Employee #3 was hired on [NJ Exec Order 26], as the Director of Wellness. The file did not contain documented evidence that the employee received orientation at the start of employment and completed the annual in-service education on emergency drills, assisted living concepts, resident rights, infection control, abuse and neglect, emergency training, Alzheimer dementia, and pain management. 4. Employee #4 was hired on [NJ Exec Order 2] as a Certified Nursing Assistant. The file did not contain documented evidence that the employee received orientation at the start of employment and completed the annual in-service education on assisted living concepts, resident rights, infection control, abuse and neglect, Alzheimer dementia, and pain management. 5. Employee #5 was hired [NJ Exec Order], as the Assistant Director of Wellness. The file did not contain documented evidence that the employee received orientation at the start of employment and	A 517		

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A 517	Continued From page 9	A 517		

completed the annual in-service education on emergency drills, assisted living concepts, resident rights, infection control, abuse and neglect, emergency training, Alzheimer dementia, and pain management.

6. Employee #6 was hired [NJ Exec Order 26.4b], as a concierge. The file did not contain documented evidence that the employee received orientation at the start of employment and completed the annual in-service education on assisted living concepts, resident rights, infection control, abuse and neglect, Alzheimer dementia, and pain management.

7. Employee #7 was hired [NJ Exec Order 26.4] as a Licensed Practical Nurse. The file did not contain documented evidence that the employee received orientation at the start of employment and completed the annual in-service education on emergency drills, assisted living concepts, resident rights, infection control, abuse and neglect, emergency training, Alzheimer dementia, and pain management.

8. Employee #8 was hired on [NJ Exec Order 26.4b] as a Housekeeping Assistant. The file did not contain documented evidence that the employee received orientation at the start of employment and completed the annual in-service education on emergency drills, assisted living concepts, resident rights, abuse and neglect, Additionally, the annual in-service education was not current on infection control (5/11/24), emergency training (5/10/24), Alzheimer dementia (6/10/24), and pain management (5/10/24).

9. Employee #9 was hired [NJ Exec Order 26], as a Certified Medication Aide. The file did not contain documented evidence that employee received

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A 517	Continued From page 10	A 517		

orientation at the start of employment and completed the annual in-service education on assisted living concepts, resident rights, infection control, abuse and neglect, emergency training, Alzheimer dementia, and pain management.

At 2:20 p.m., the surveyor interviewed the Business Office Manager (BOM) and inquired about the employees orientation upon employment. The BOM stated that she recently began auditing the files and explained that she has not completed the audits and acknowledged that the files were incomplete. The surveyor inquired about the facility's process on ensuring annual in-services were completed and the BOM stated that there was no system in place to ensure that all required in-services were completed.

The surveyor reviewed the facility policy and procedure dated for 1/1/2021 and titled, "Team Member Files" which revealed that "... Procedure: 1. The Business Operations Director (BOD) is responsible for keeping a current file for every team member working at the community. The team member file will contain, at a minimum, the following: ... j. Training records ..."

In addition, the surveyor reviewed the facility policy and procedure dated for 6/22/2022 and titled, "Team Member Training" which revealed that " Policy: The community will provide new team member orientation and annual on-going training ... 1. The community will conduct a New Team Member Orientation for all new team members that will be completed prior to the new team member beginning their assigned work duties. 2. The New Team Member Orientation will include, at a minimum: a ... concepts of assisted living ... b. Emergency plans and procedures c.

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A 517	Continued From page 11 Infection prevention and control program d. Resident Rights e. Abuse and neglect f. Pain management g. Care of residents with Alzheimer's ... 3. New team Member Orientation will be documented, and a copy kept in the team member's personnel file ..."	A 517		
A 783	8:36-7.5(e) Resident Assessments and Care Plans (e) Each resident shall have an annual physical examination by a physician, advanced practice nurse or physician assistant, which shall be documented in the resident's record. The physician, advanced practice nurse or physician assistant shall certify annually that the resident does not have needs which exceed the care that the facility or program is capable of providing. This REQUIREMENT is not met as evidenced by: Based on record review and review of other pertinent facility documents, it was determined that the facility failed to ensure that each resident had an annual physical examination with annual physician certification documented in their Medical Record (MR) for 4 of 7 residents reviewed, Resident #s 2, 3, 4, and 6. This deficient practice was evidenced by the following: On 10/16/25, the surveyor reviewed the MR of Resident #s 2, 3, 4, and 6, which revealed the following: 1. Resident #2's last annual physical examination with physician certification was on [redacted].	A 783		

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A 783	Continued From page 12 2. Resident #3's last annual physical examination with physician certification was on [NJ Exec Order 26]. 3. Resident #4's last annual physical examination with physician certification was on [NJ Exec Order]. 4. Resident #6's last annual physical examination with physician certification was on [NJ Exec Order 26]. The surveyor reviewed the facility's "Residency Agreement," which indicated, "... The Community shall determine whether the Resident requires the Customized Support Assessment Program through a professional registered nurse assessment and/or Physician evaluation on admission, at least annually, or with change in condition. The annual medical certification will be completed by the physician or advanced practice nurse in order to certify that the resident is appropriate to reside at the community ..."	A 783		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code.	A 891		

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A 891	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to comply with the provisions of Chapter 24, N.J.A.C. 8:24. "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines," which placed 115 of 115 residents at risk for foodborne illnesses. This deficient practice was evidenced by the following: On 10/15/25 at 9:49 p.m., the surveyor toured the facility's kitchen and observed the following: 1. (1) open and undated 48 Fluid (fl.) Ounce (oz) bottle of [redacted] Prune Juice (1) open and undated 64 fl. oz carton of Silk Almond Milk (1) open and undated gallon of [redacted] Skim Milk 2. A brownish substance inside of the ice machine. 3. An unclean can opener with build-up. At this time, the surveyor interviewed the Culinary Service Director (CSD) to inquire the reason the previously mentioned items were not labeled, and the CSD stated that it was not required by the county. In addition, the surveyor showed the CSD the ice machine and can opener and inquired how often they were cleaned. The CSD stated that the ice machine was cleaned quarterly by a third-party service and that the brown substance was due to "hard water". The CSD then stated that the can opener was cleaned three times a week.	A 891		

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A 891	Continued From page 14	A 891		

At 10:19 a.m., the surveyor reviewed food temperature logs, which revealed an undated and incomplete log, and no food temperature log for 10/15/25. At this time, the surveyor also reviewed the refrigerator/freezer temperature log, which revealed missing documentation for 10/3, 10/4, 10/6, 10/7, 10/8, 10/9, 10/10, 10/11, 10/12, and 10/14/25, and no documentation for 10/13, 10/15, and 10/16/25.

At this time, the surveyor interviewed the Cook to inquire if he checked the temperature of breakfast foods. The Cook stated that he checked the temperature of breakfast foods but did not yet complete the temperature log. The surveyor then asked the Cook how he was able to remember all the food temperatures to document the temperatures later, and the Cook stated, "I've been doing this a long time, didn't write it down, this is just how I do it."

On 10/16/25 at 9:19 a.m., the surveyor toured the memory care unit and observed that the refrigerator was unclean. The surveyor also observed a 46 fl. oz. open and undated carton of NJ Ex Order 26 Imperial Thickened Apple Juice from Concentrate. The carton indicated that the apple juice could be kept for up to seven days after being opened. Further, the surveyor reviewed the refrigerator temperature log posted on the memory care refrigerator, which revealed no documented temperatures for 10/5, 10/6, 10/7, 10/10, 10/11, 10/12, 10/14, or 10/16/25.

At 9:29 a.m., the surveyor toured the "Serenade Bar," and observed what appeared to be an ice machine, with a blackish-gray substance throughout the inside.

At 1:18 p.m., the surveyor toured the walk-in

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refrigerator located in the basement, in the presence of the Dietary Supervisor. The surveyor observed NJ Ex Order 26.4(b)(1) Ham, NJ Ex Order 26.4 Salami, NJ Ex Order 26.4(b)(1) Ham, NJ Ex Order 26.4(b)(1), and Hickory Smoked Pork Roll all open and undated. In addition, the surveyor observed the following:

(1) open and undated 5-pound (lb.) container of NJ Ex Order 26.4 Ricotta Cheese
(1) open and undated 2 lb. bag of NJ Ex Order 26.4(b)(1) Goat Cheese Crumbles
(1) open and undated 5 lb. bag of NJ Ex Order 26.4 Shredded Mozzarella Cheese

At this time, the surveyor also toured the dry storage area in the basement and observed an unlabeled canned food that was approximately 6 lbs.

The surveyor reviewed the facility's policy titled, "Equipment Cleaning & Sanitizing," revised on 1/1/21, which indicated, "POLICY: Equipment is washed, rinsed and sanitized after each use to ensure the safety of food served to residents. PROCEDURE: All culinary services team members who use equipment will be responsible for washing and sanitizing removable parts after each use ..."

The surveyor also reviewed the facility's policy titled, "Receiving Food," revised on 1/1/21, which indicated, "... 8. Reject food with damaged packaging such as torn bags or cans with swelled tops or bottoms, leakage, incomplete labels, flawed seals, rust, or dents ..."

In addition, the surveyor reviewed the facility's policy titled, "Service Temperatures," revised on 1/1/21, which indicated, "POLICY: Temperatures of all hot and cold foods are taken during service

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A 891	Continued From page 16 to assure that foods are maintained at appropriate temperatures to ensure the safety of food served to residents ... 4. Record temperatures on the Service Temperature Log and initial ... 8. The Culinary Services Director (CSD) will: a. Check logs on a daily basis to ensure that they are completed and that temperatures are appropriate ..." Lastly, the surveyor reviewed the facility's policy titled, "Kitchen Safety," revised on 1/1/21, which indicated, "POLICY: The community will maintain safety precautions and processes to ensure a safe work environment, and a sanitary environment for preparing, serving, and storing food ..."	A 891		
A 925	8:36-11.2 Pharmaceutical Services The assisted living residence, comprehensive personal care home, or assisted living program shall be capable of ensuring that pharmaceutical services are provided to residents in accordance with the prescriber's orders, each resident's health care plan, and in accordance with the rules of this chapter and all applicable State and Federal laws and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to ensure that medication was administered to residents in accordance with the prescriber's orders, the shift [redacted] count records were consistently completed at the beginning and end of each shift,	A 925		

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A 925	Continued From page 17	A 925		

and documentation was completed following wound care treatment for 6 of 7 residents reviewed, Resident #'s 1, 2, 3, 4, 5, and 6. This deficient practice was evidenced by the following:

On 10/16/25, the surveyor reviewed the Medical Record (MR) of Resident #3, which revealed that the resident was admitted to the facility in [redacted] of [redacted] with a diagnosis of [redacted].

1. At 10:31 a.m., the surveyor observed CMA #10 administer medication to Resident #3. At this time, the surveyor inquired when Resident #3's medications were due to be administered. CMA #10 stated that Resident #3's medications were due to be administered at 9:00 a.m. and that they were late. Additionally, CMA #10 stated that she was asked to help CMA #9, who usually administered medications to all residents on the second floor.

At 10:52 a.m., the surveyor observed CMA #10 prepare to administer medications to another resident. At this time, the surveyor inquired if medications were often administered late on the second floor, and CMA #10 stated yes.

At 10:59 a.m., the surveyor interviewed CMA #9, who regularly worked on the second floor, to inquire what time she usually completed her 9:00 a.m. medication pass. CMA #9 stated that she would usually complete her medication pass by 10:30 a.m. CMA #9 explained that she told the Assistant Director of Nursing (ADON) and the former Director of Nursing (DON) that working the second floor alone was "a lot".

On 10/15/25, the surveyor conducted a medication administration observation with Licensed Practical Nurse (LPN) #7 and CMA #9

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A 925	Continued From page 18	A 925		

which revealed the following:

1. At 10:10 a.m., the surveyor reviewed Resident #1's MR which revealed that the resident was admitted to the facility in [redacted] of [redacted] with a diagnoses of [redacted] and [redacted]. Resident #1 was ordered [redacted] care with special instructions to [redacted] with [redacted], apply [redacted] to [redacted] twice a day at 6:00 a.m. and 7:00 p.m. The MAR for this order was red indicating the treatment was not documented as being completed by the nurse.

2. At 10:31 a.m., the surveyor reviewed Resident #4's MR which revealed that the resident was admitted to the facility in [redacted] of [redacted] with a diagnosis of [redacted]. Resident #4 received the following medications from CMA #9 at 10:31 a.m., after the ordered time window:

[redacted]) [redacted] 1 tablet at 9:00 a.m.
[redacted] 1 tablet at 10:30 a.m.
[redacted] at 9:00 a.m.
[redacted] each [redacted] at 9:00 a.m.
[redacted] tablet at 9:00 a.m.
[redacted] at 9:00 a.m.

4. On 10/15/25 at 9:56 a.m., the surveyor reviewed Resident #5's MR which revealed that the resident was admitted to the facility in [redacted] of

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A 925	Continued From page 19 NJ Exec Orc with a diagnosis of NJ Exec Order 26.4b1 Resident #5 was ordered a NJ Exec Order 26.4b1 check at 8:00 a.m. and alert the [physician] if NJ Exec Order 26.4 [redacted]. LPN #7 obtained the ordered NJ Exec Order 26.4b1 at 9:56 a.m. 5. On 10/15/25 at 9:39 a.m., the surveyor reviewed Resident #6's MR which revealed that the resident was admitted to the facility in NJ Exec Order 26.4b1 with a diagnosis of NJ Exec Order 26.4b1 The surveyor observed that LPN #7 signed out the Medication Administration Record (MAR) without the administering the following medications to Resident #6: NJ Exec Order 26.4b1 [redacted] 1 tablet at 9:00 a.m. NJ Exec Order 26.4b1 [redacted] (a medication used to treat NJ Exec Ord 1 tablet at 9:00 a.m. NJ Exec Order 26.4b1 [redacted]) 1 tablet at 9:00 a.m. NJ Exec Order 26.4b1 [redacted]) 1 tablet at 9:00 a.m. NJ Exec Order 26.4b1 [redacted] at 9:00 a.m. NJ Exec Order 26.4b1 [redacted] 1 tablet at 9:00 a.m. NJ Exec Order 26.4b1 [redacted]) 1 tablet at 9:00 a.m. NJ Exec Order 26.4b1 [redacted]) 1 tablet at 9:00 a.m. The surveyor inquired about Resident #6's medication administration. LPN #7 stated that she administered Resident #6's medication around 8:00 a.m., but was called to an emergency and did sign out the medication administration.	A 925		

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A 925	Continued From page 20 The surveyor reviewed the undated facility's policy and procedure titled, "The Process for Delegation of Medication Administration," "Procedure" indicated, "... 5. The nurse shall maintain full responsibility for: a. Communication with resident's physicians and pharmacists concerning medication issues ... 6. Certified Medication Aide shall: a. Be advised to communicate exclusively with the delegating nurse regarding all medication matters." The surveyor also reviewed the facility's policy and procedure dated 3/21/23 titled, "Medication administration," which indicated, " ... Procedure: 1. Medications will be administered to residents within one hour before or one hour after the prescribed or scheduled time, ... 2. During the med pass, the med-passer will assure the Twelve Rights of Medication Administration, and then pass the medication(s) ... d. Right time/frequency ... i. RIGHT Documentation ... 3. The team member administering medications will document	A 925		
A1011	8:36-11.7(k) Pharmaceutical Services (k) Controlled dangerous substances shall be stored, and records shall be maintained, in accordance with the Controlled Dangerous Substances Acts, N.J.S.A. 24:21-1 et seq. and all other Federal and State laws and regulations concerning the procurement, storage, dispensation, administration, and disposition of same. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	A1011		

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review, it was determined that the facility failed to ensure that the Shift Narcotic Count Record (SNCR) shift-to-shift signature log used to ensure accountability of controlled substances was consistently conducted and signed by staff for 1 of 3 medication carts (MC), MC #1. This deficient practice was evidenced by the following:

On 2/26/25 at 10:07 a.m., following a narcotic count with the Licensed Practical Nurse (LPN), the surveyor reviewed the SNCR for MC #1. Upon review, the surveyor observed that there were blank spaces in the SNCR where staff signed to indicate that controlled narcotic count was correct upon change of shift.

Continued surveyor review of the SNCR, revealed that there were ten missing on-coming and off-going signature blanks from 7/28/25 through 8/20/25 on page #1, 9 missing signature blanks from 8/21/25 through 9/13/25 on page #2, twenty-one missing signature blanks dated 9/14/25 through [10/9/25] on page #3, and five missing signature blanks on page #4 dated 10/10/25 through 10/15/25.

Following review of the SNCR, the surveyor asked the LPN what the procedure was for shift-to-shift controlled substance counts. The LPN explained that the oncoming staff member completed counts for each controlled substance with the off going staff member each shift, and then both signed their signatures to confirm that the count was correct.

On 10/16/25 at p.m., the surveyor interviewed a Float Registered Nurse (FRN) regarding the missing staff signatures on the SNCR. The FRN stated that the SNCR was reviewed weekly. Additionally, the FRN stated that if a nurse failed

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A1011	Continued From page 22 to document the narcotic counts, they were required to come in and complete the missing documentation. The surveyor also reviewed the facility's policy and procedure dated 7/17/24 titled, "Controlled Substances," which indicated, " ... 4. Two authorized members of the Health & Wellness Department including but not limited to: the HWD, WN, MT, or Care manager (CM), will count and verify all narcotics in the community, and document the count, along with their signatures ..."	A1011		
A1033	8:36-14.2(a) Emergency Services and Procedures (a) The facility shall develop written emergency plans, policies, and procedures which shall include plans and procedures to be followed in case of medical emergencies, power failures, fire, and natural disasters. The emergency plans shall be filed with the Department and the Department shall be notified when the plans are changed. Copies of emergency plans shall also be forwarded to other agencies in accordance with State and municipal laws. This REQUIREMENT is not met as evidenced by: Based on interview and record review on 10/16/2025, in the presence of the Executive Director (ED) and Director of Maintenance (DOM), it was determined that the facility failed to ensure that the Emergency Preparedness Plan (EPP) was reviewed and updated at least every two years, in accordance with Appendix Z, Emergency Preparedness for all Provider and	A1033		

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A1033	Continued From page 23 Supplier Types. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 10/16/2025 of the EPP revealed: 1. No signature page indicating review of the EPP program for the year 2025 or any previous years. 2. Memorandum of Understanding's (MOU'S) dated 8/19/11 - 3/10/16 3. No revision dates within the last two years for any policies and procedures. During an interview at 11:00 a.m., the ED confirmed the EPP had not been updated or sent into the local authorities, i.e. OEM, for review. The facility's ED was informed of the deficient practice during the Life Safety Code exit conference at 1:15 p.m.	A1033		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice. This REQUIREMENT is not met as evidenced	A1073		

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A1073	Continued From page 24 by: Based on observation, interview and record review, it was determined that the facility failed to ensure that the NJ Exec Order 26.4b1 reading was documented in the Medication Admsinitration Record (MAR) for 1 of 7 residents, Resident #5. This deficient practice was evidenced by the following: On 10/16/25 at 10:15 a.m., the surveyor reviewed Resident #5's medical record (MR) which revealed that Resident #5 moved into the facility in NJ Exec Order 26.4b1, with diagnoses of NJ Exec Order 26.4b1 Further review of Resident #5's MAR revealed that Resident #5 had an order for NJ Exec Order 26.4b1 checks every morning at 8 a.m. On 10/15/25 at 9:56 a.m., the surveyor performed a medication observation with a Licensed Practical Nurse (LPN) #7. The surveyor observed LPN #7 obtain a NJ Exec Order 26.4b1 on Resident #5 which read NJ Exec Order 26.4b1. The LPN did not document the NJ Exec Order 26.4b1 reading and stated that she was going to administer Resident #5's ordered NJ Exec Order 26.4b1 medications and then recheck the NJ Exec Order 26.4b1. LPN #7 stated that she would document the reading she got after administering the NJ Exec Order 26.4b1 medications if the NJ Exec Order 26.4b1 . At 2: 02 p.m., the surveyor interviewed the Float Registered Nurse (FRN) and inquired about vital sign documentation. The FRN stated that nurses were expected to document in the MAR NJ Exec Orde reading even if the NJ Exec Order 26.4b1 reading was NJ Exec Orde The surveyor reviewed the facility policy and procedure dated for 3/21/2023 and titled,	A1073		

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A1073	Continued From page 25 "Medication Administration" which revealed that " Procedure: 2. During med pass, the med-passer will assure the Twelve Rights of Medication Admsinitration ... j. RIGHT evaluation ... 3. The team member administering medications will document on the Resident's electronic Medication Admsinitration Record (eMAR) ... "	A1073		
A1095	8:36-16.5(b) Physical Plant (b) All fire detection systems shall be installed in accordance with the Uniform Construction Code, N.J.A.C. 5:23, N.J.A.C. 5:70 and the National Fire Alarm Code, National Fire Protection Association (NFPA) 72, 1999 Edition, incorporated herein by reference, as amended and supplemented. National Fire Protection Association publications are available from: NFPA, One Batterymarch Park, Quincy, MA, 02269-9101. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure a sensitivity testing of smoke detectors was conducted every alternate year in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70 and NFPA 72. This deficient practice had the potential to affect all Residents and was evidenced by the following: On 10/16/25, the Director of Maintenance (DOM) provided all fire alarm documents from the facility vendor, however, the inspection reports did not indicate when the last smoke detector sensitivity	A1095		

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A1095	Continued From page 26 testing was conducted in the building. At 12:00 p.m., the DOM stated that he was unaware of the requirement and was unable to locate any smoke detector sensitivity testing documentation. At 1:15 p.m., the surveyor informed the Executive Director of the above concern during the exit conference. NJAC 5:23, N.J.A.C 5:70 NFPA 72, 1999 Edition	A1095		
A1097	8:36-16.6 Physical Plant All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that fire sprinkler systems were Inspected, Tested and Maintained (ITM) in accordance with NFPA 25:2011 Edition, Section 5.1.3, Table 5.1.1.2, 14.2.1, 5.2.4 and 5.3.2. This deficient practice was evidenced by the following:	A1097		

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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
A1097	Continued From page 27 1. A documentation review on 10/16/2025 revealed that documentation of a 5- year obstruction, internal inspection of piping, could not be found for the sprinkler systems. During interview with the Executive Director and the Director of Maintenance, both confirmed the documentation review. 2. A documentation review on 10/16/2025 revealed the facility had an electric fire pump. No documentation of weekly testing was provided within the facilities Life Safety Binder ensureing that the automatic sprinkler system fire pump was in optimal condition in accordance with the National Fire Protection Association (NFPA) 20 & 25. At 12:00 p.m., the Director of Maintenance (MD) confirmed the document review and stated that he was unaware of the required weekly testing. The facility's Executive Director was informed of the deficient practice during the Life Safety Code exit conference at 1:15 p.m. NJAC 8:39-31.1(c), 31.2(e) NFPA 20, 25	A1097		
A1183	8:36-17.2(a) Housekeeping-Sanitation-Safety-Maintenance (a) A written work plan for housekeeping operations shall be established and implemented, with categorization of cleaning assignments as daily, weekly, monthly, or annually within each area of the facility. The facility shall have a written	A1183		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10A002	A. BUILDING: _____ B. WING _____	C 10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING @ MOORESTOWN	1205 N. CHURCH STREET MOORESTOWN, NJ 08057

(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
A1183	Continued From page 28 schedule that determines the frequency of cleaning and maintenance of all equipment, structures, areas, and systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to establish a written work plan for the cleaning of lint from commercial dryers. This deficient practice was evidenced by the following: On 10/16/25 at 12:02 p.m., the surveyor toured the laundry room in the presence of the Executive Director (ED) and the Director of Maintenance (DOM). The surveyor observed that there were no cleaning schedule logs posted on the commercial laundry dryers. At 12:05 p.m., the surveyor interviewed the DOM regarding a written schedule for the cleaning and maintenance of the commercial dryers. The DOM stated that the facility did not have a contract with a cleaning service company to clean the lint from the commercial dryer vents and exhausts. The DOM was unable to provide service records and logs for the required cleaning of the lint and explained that they were in the process of switching contracts to another cleaning company.	A1183		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1249	Continued From page 29 ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the building was well maintained at all times. This deficient practice was evidenced by the following: On 10/16/25 at 9:56 a.m., the surveyor inspected resident apartment #278 in the presence of the Executive Director (ED) and the Maintenance Director (DOM). One of the resident's bathroom in apartment #[redacted] had a water stain with a dark, black mold like substance on the ceiling tile by the exhaust vent. At 10:00 a.m., the surveyor interviewed the DOM about the black mold like substance on the ceiling. The DOM stated that he knew about the black mold and stated that the Heating Ventilation and Air Conditioning (HVAC) system duct runs right next to the bathroom exhaust vent and had been leaking on the ceiling tiles. The DOM stated that they have the HVAC company scheduled for repairs. At 12:02 p.m., the surveyor toured the first floor in the presence of the ED and DOM. In Stairwell 2, the surveyor observed water stains on the ceiling	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10A002	A. BUILDING: _____ B. WING _____	C 10/16/2025

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A1249	Continued From page 30 with a dark, black mold-like substance on the ceiling. At 12:05 p.m., the surveyor interviewed the ED and DOM regarding the ceiling in Stairwell 2. The DOM stated he was unaware of the concern and acknowledged the findings. The ED stated that they had issues with mold in December of 2024, prior to the ED and DOM being hired for this facility.	A1249		
A1309	8:36-18.4(a)(2) Infection Prevention and Control Services (a) Each new employee upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 2. If the Mantoux test is significant (10 millimeters or more of induration), a chest x-ray shall be performed and, if necessary, followed by chemoprophylaxis or therapy. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of	A1309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1309	Continued From page 31	A1309		

other pertinent facility documents, it was determined that the facility failed to ensure that employees received a NJ Exec Order 26.4b1 [redacted] for 5 of 9 employees reviewed, Employee #s 1, 2, 5, 6, and 8. This deficient practice was evidenced by the following:

On 10/16/25, the surveyor reviewed Employee #1's personnel record, which revealed that the employee received a NJ Exec Order 26.4b1 on NJ Exec Order 26. The surveyor did not observe any annual NJ Exe testing for 2024 or 2025.

In addition, the surveyor reviewed the personnel records of Employee #s 2, 5, 6, and 8, which revealed that the employees did not have any documentation of a NJ Exe test.

At 2:22 p.m., the surveyor interviewed the Business Office Manager (BOM) to inquire how often NJ Exe testing was completed. The BOM stated that NJ Exe tests were completed on hire unless employees were able to provide a NJ Ex Order 26.4(b)(1) test that was completed within 45 days. At this time, the BOM also stated that employees had the option to complete an annual NJ Exe questionnaire or get an annual NJ Exe shot.

The surveyor reviewed the facility's policy titled, "New Team Member Screening," revised on 1/1/21, which indicated, "... PPD Prior to their start date and then again annually, each team member is required to receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative, or other approved method ..."

BRANDYWINE by MONARCH COMMUNITIES

January 7th, 2025

A269 8:36-3.1(a) Administration

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.* **On 10/28/2025 the Health and Wellness Director was appointed alternate administrator. The alternate health and wellness director is the assistant health and wellness director who is also a registered nurse. The health and wellness director reviewed and signed her job description on 12/12/2026 and it has been uploaded to her employee file.**
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.* **All residents have the potential to be affected.**
3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.* **On 10/28/2025 the Executive Director posted a sign in the lobby designating the Health and Wellness Director as the appointed alternate administrator and staff have been in-serviced. The in service was started on 10/28/2025 completed by the Executive Director. For new staff members the business office manager will inform them of the alternate administrator during their orientation. During the orientation new staff meet each department head including the alternate administrator.**
4. *How the facility will monitor its corrective actions to ensure that the deficient practice is n being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.* **The administrator will ensure that the alternate administrator designee is up to date and posted each QA/QI meeting. This is held quarterly.**
5. *Completion Date for this tag:* **January 6th 2026 and ongoing**

NJ Exec Order 26.4b [redacted]

Tag A 310 8:36-3.4 (a) (1) Administration

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.* ***On 12/1/2025 the health and wellness director began staff education on the policy of Medication Storage*** **including blister packs and medication integrity.**
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.* **All residents have the potential to be affected.**
3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.* **Starting 12/1/2025, Wellness Director or RN Designee will complete bi-weekly audits of the Medication bingo cards.**
4. *How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.* **Starting 12/1/2025, Wellness Director or RN Designee will complete bi-weekly audits of the Medication bingo cards for three months. ED will review audit results quarterly during QA/QI meeting.**
5. *Completion Date for this tag:* **December 31st Ongoing**

NJ Exec Order 26.4b [redacted]

Tag 355 8:36-4.1(a)(1) Resident Rights

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.* ***On 10/26/25 RN updated Resident # 3's General Service Plan to include continence checks twice per shift. The health and wellness director began staff education on Service plan updates on*** NJ Exec Order 26.4b1 [redacted] ***Resident # 3 Dx of*** NJ Exec Order 26.4b1 [redacted]
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.* **All residents have the potential to be affected.**

3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.* **Care Staff will document incontinence checks using community EHR. Wellness Director or RN designee will complete biweekly audits to ensure compliance for 3 months.**
4. *How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.* **ED will review audit results quarterly during QA/QI for one quarter.**
5. *Completion Date for this tag:* **December 30th Ongoing**

Tag A 517 8:36-5.6(b)(1-7) General Requirements

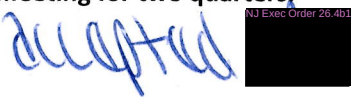
1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.*
   - ***Community Business office manager began an audit on January 1st of all Team Member files to ensure the General Orientation Checklist and will make sure each staff has theirs completed by January 6th.***
   - ***Business Office Manager was in-serviced on 10/28/2025 of the policy titled "Team Member Training" by the executive director. Staff members # 1,2,3,6, 9 and 10 have been competed. Staff members # 4, 5, and 7 have are no longer with the company. Staff member # 8 will be completed by January 11th.***
   - ***The Business Office Manager along with the Executive Director will complete an audit of all Team member files to ensure compliance with all required annual trainings listed in 8:36-5.6 (b)(1-7) General Requirements.***
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.* **All residents have the potential to be affected.**
3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.*
   - ***Community Business office manager will complete an audit of all Team Member files to ensure the General Orientation Checklist has been completed.***
   - ***Business Office Manager has been in-serviced by the executive director on 10/28/2025 of the policy titled "Team Member Training".***
   - ***Business Office Manager/ ED will complete an audit of all Team member files to ensure compliance with all required annual trainings listed in 8:36-5.6 (b)(1-7) General Requirements.***
4. *How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.* **Executive Director will audit new hire files monthly for 12 months to ensure compliance. Audit results will be reviewed by community leadership team quarterly during QA/QI meeting for 4 Quarters.**
5. *Completion Date for this tag:* **December 31st Ongoing**

Tag 783 8:36-7.5(e) Residents and Care Plans

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice?* ***The residents were not affected by this deficient practice. Community received updated History & Physical annual examinations for residents #2 was received on*** [NJ Exec Order 26.4b1] ***3 on*** [NJ Exec Order 26.4b1] ***4 was received on*** [NJ Exec Order 26.4b1] ***6 was received on*** [NJ Exec Order 26.4b1]
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.* **All residents have the potential to be affected.**
3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.*
   - ***Wellness Director or designee completed an audit of all resident files to identify any non-compliant annual examinations. The start date was December 15thCompletion Date is 12/31/2025.***

- ***The assistant director of health and wellness implemented a tickler to monitor the history and physicals on December 15th 2025to monitor ongoing compliance. The assistant health and wellness director will be responsible for update the tickler. This will be reviewed monthly.***

4. *How the facility will monitor its corrective actions to ensure that the deficient practice is n being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.* **Tickler list will be reviewed by the Wellness Director or designee monthly ongoing to ensure compliance. ED will review compliance during quarterly QA/QI meeting for two quarters.**
5. *Completion Date for this tag:* **December 31st Ongoing**



Tag A 891 8:36-10.5(a) Dining Services

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice?*
   - ***All culinary team members have been in-serviced by the Culinary Services Director the policies titled "Kitchen Safety", "Equipment Cleaning & Sanitizing", "Receiving Food", and "Service Temperatures" on 10/16/2025.***
   - ***The culinary services director cleaned and sanitized the can opener and Ice machine per policy on 10/16/2025.***
   - ***The culinary services director audited all food to ensure food items were dated & wrapped on 10/16/2025.***
   - ***One 12/10/2025 and 12/12/2025 The Life Enrichment Director completed an in service on refrigerator temperature logs.***
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.* **All residents have the potential to be affected.**
3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.* **Culinary Services Director or designee will complete daily audits to ensure compliance. ED will complete weekly audits for 8 weeks to ensure compliance.**
4. *How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.* **Culinary Services Director or designee will complete daily audits to ensure compliance. ED will complete weekly audits for 8 weeks to ensure compliance and review audit results during QA/QI meeting.**
5. *Completion Date for this tag:* **October 28th Ongoing**

Tag A 925 8:36-11.2 Pharmaceutical Services

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice?* ***Residents 1, 3, 4, 5, 6 were assessed and were not affected by the deficient practice.***
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.* **All residents have the potential to be affected.**
3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.*
   - **On 12/15/2025 and 12/16/2025 Senior Wellness Director, ED & Wellness Director reviewed medication pass and medication carts for all areas of the community.**
   - **Senior WD & Wellness Director reviewed the policy titled "The process for delegation of Medication Administration".**
   - **The health and wellness director in serviced the Wellness nurses and Certified Medications aides in-serviced on the policy of "Medication Administration" on 12/1/2025.**
   - **Wellness Director & facility RN will work with consultant pharmacist & resident physicians to review resident medications.**

How the facility will monitor its corrective actions to ensure that the deficient practice is n being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. **Wellness Director/ RN Designee will monitor medication administration times/ documentation daily. Medication pass times**

were audited and there will be continuous monitoring morning forward by the Health and Wellness Director. Additionally, we ca have the physicians do a med review monthly to ensure that there is no polypharmacy occurring and address when needed

4. **. ED will review audit results at QA/QI meeting.**
5. *Completion Date for this tag:* **December 31st Ongoing**

Tag A 1011 8:36-11.7 (k) Pharmaceutical Services

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice* ***The Health and Wellness Director in serviced*** **Wellness nurses/Certified Medication Aides on how to follow policy titled "Controlled substances" including completion of Narcotic count by two authorized individuals.**
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.* **All residents have the potential to be affected.**
3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.*
   - ***Wellness nurses/ Certified Medication Aides in-serviced on policy titled "Controlled substances" on 12/1/2025.***
   - ***Health and Wellness Director/ RN designee will audit compliance daily. ED will review audit results during QA/QI meeting.***
4. *How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.*
   - ***ED will review audit results during QA/QI meeting.***

Completion Date for this tag: **December 31st Ongoing**

Tag A 1033 8:36-14.2 (a)Emergency Services and Procedures

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice?* ***The Emergency Preparedness Plan has been reviewed by facility Executive Director. ED will send the plan to the local authorities to include the local fire department and county OEM for review & approval. The signature page will be kept in the Emergency Preparedness Manual.***
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.* **All residents have the potential to be affected.**
3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.*
   - ***Environmental Services Director in-serviced on requirements of 8:36-14.2 (a) Emergency Services & Procedures.***
   - ***ED will review Emergency Preparedness Plan annually and sign/date for compliance.***
4. *How the facility will monitor its corrective actions to ensure that the deficient practice is n being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.* ***ED will review Emergency Preparedness Plan annually and sign/date for compliance.***
5. *Completion Date for this tag:* **January 15th Ongoing**

Tag A8:36-15.6(b) 1073 Resident Records

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice?* ***Resident #5's medication administered as ordered at 8:00am on Daily.*** NJ Exec Order 26.4b1 ***documented at 9:00 a.m. Residents # 5 was not affected by the deficient practice. LPN # 7 received an in service on 12.1.2025.***
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.* **All residents have the potential to be affected.**
3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.*

- ***The health and wellness director in serviced the Wellness nurses on policy titled "Medication Administration" on 12/1/2025. Staff was informed to let an RN know of elevated blood pressures when found.***
- ***Wellness Nurses/ Certified Medication Aides will follow "Medication Administration" policy.***

4. *How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.*
   - ***Wellness Director/ RN designee will audit compliance daily. ED will review audit results during QA/QI meeting.***
5. *Completion Date for this tag:* **December 31st Ongoing**

accepted [redacted]

Tag A 1095 8:36-16.5(b) Physical Plant

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice?* ***Smoke detector sensitivity test scheduled/ completed on 2/19/2026 and 2/20/2026.***
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.* **All residents have the potential to be affected.**
3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.*
   - ***Environmental Services Director reviewed NJAC 5:23 and NJAC 5:70.***
   make Sensitivity Testing has been added to the facility's preventative maintenance plan.
4. *How the facility will monitor its corrective actions to ensure that the deficient practice is n being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.* **Executive Director will audit compliance by documentation review and use of facility's preventative maintenance program annually during QA/QI.**
5. *Completion Date for this tag:* **January 31st Ongoing**

accepted by Life Safety

Tag A 1097 8:36-16.6 Physical Plant

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice* **The director of Environmental Services scheduled the five-year sprinkler inspection for March of 2026 with an outside vendor**
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.* **All residents have the potential to be affected.**
3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.*
   - ***Community is contracted with Elie Fire to ensure compliance of 5-year obstruction & internal inspection of piping.***
   5 Year inspection has been added to the facility's preventative maintenance plan.
   - **Executive Director will audit compliance by documentation review and use of facility's preventative maintenance program annually during QA/QI.**
4. *How the facility will monitor its corrective actions to ensure that the deficient practice is n being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.* **Executive Director will audit compliance by documentation review and use of facility's preventative maintenance program annually during QA/QI.**

accepted by Life Safety

5. *Completion Date for this tag:* **January 31st Ongoing**

Tag A 1183 8:36-17.2 (a) Housekeeping-Sanitation-Safety Maintenance

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice* **Systematic Cleaning completed cleaning of the commercial dryers on 11/11/2025.**
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.* **All**

residents have the potential to be affected.

3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.*
   - ***Agreement with Systematic Cleaning for service to be completed quarterly.***
   - ***Commercial dryer lint cleaning added to facility's preventative maintenance program..***
   - **Executive Director will audit compliance by documentation review and use of facility's preventative maintenance program quarterly during QA/QI for two quarters.**
4. *How the facility will monitor its corrective actions to ensure that the deficient practice is n being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.* **Executive Director will audit compliance by documentation review and use of facility's preventative maintenance program quarterly during QA/QI for two quarters.**
5. *Completion Date for this tag:* **November 11th Ongoing**

accepted by Life Safety

Tag A 1249 8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice?* ***Servpro completed repair of Stairwell #2 & apartment # [redacted] on 10.24.2025.***
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.* **All residents have the potential to be affected.**
3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.*
   - ***Environmental Services Director, Maintenance Assistant, and housekeeping staff in-serviced on reporting necessary repairs in facility timely.***
   - ***Environmental Services Director will inspect all common areas and 10% of resident apartments monthly for 12 months to monitor the need for repairs/ leaks.***
4. *How the facility will monitor its corrective actions to ensure that the deficient practice is n being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.* **Executive Director will audit compliance by documentation review and use of facility's preventative maintenance program quarterly during QA/QI for three quarters.**
5. *Completion Date for this tag:* **10.24.2025 Ongoing**

accepted by Life Safety

Tag A 1309 8:36-18.4(a)(2) Infection Prevention and Control Services

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice?* ***Annual [redacted] screening completed for employee #1, 2, 5, 6, 8 completed on 1/31/2026. The business office manger is working with [redacted] to receive copies or the [redacted] test when hired.***
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.* **All residents have the potential to be affected.**
3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.*
   - ***Business Office Manager was in-serviced by the executive director on policy titled "New Team Member Screening" on 10/28/2025.***
   - ***Business Office Manager completed an audit of all Team Member on 12/1/2025 files to identify any other team members out of compliance.***
   - ***Business office Manager will utilize a tickler system to monitor compliance of annual TB screenings created on 12/1/2025.***
4. *How the facility will monitor its corrective actions to ensure that the deficient practice is n being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.* **Executive Director will audit new hire files monthly for 12 months to ensure compliance. Audit results will be reviewed by community leadership team quarterly during QA/QI meeting for 4 Quarters.**
5. *Completion Date for this tag:* **January 31st Ongoing**

accepted [redacted]

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
10A002		1/9/2026

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING @ MOORESTOWN	1205 N. CHURCH STREET MOORESTOWN, NJ 08057

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 A0355 Reg. # 8:36-4.1(a)(1) LSC	Correction Completed 01/09/2026	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
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

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	
10/16/2025	☐ 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
10A002 Y1	A. Building B. Wing Y2	1/9/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING @ MOORESTOWN	1205 N. CHURCH STREET MOORESTOWN, NJ 08057

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 A0269 Reg. # 8:36-3.1(a) LSC	Correction Completed 01/09/2026	ID Prefix A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 01/09/2026	ID Prefix A0355 Reg. # 8:36-4.1(a)(1) LSC	Correction Completed 01/09/2026
ID Prefix A0517 Reg. # 8:36-5.6(b)(1-7) LSC	Correction Completed 01/09/2026	ID Prefix A0783 Reg. # 8:36-7.5(e) LSC	Correction Completed 01/09/2026	ID Prefix A0891 Reg. # 8:36-10.5(a) LSC	Correction Completed 01/09/2026
ID Prefix A0925 Reg. # 8:36-11.2 LSC	Correction Completed 01/09/2026	ID Prefix A1011 Reg. # 8:36-11.7(k) LSC	Correction Completed 01/09/2026	ID Prefix A1033 Reg. # 8:36-14.2(a) LSC	Correction Completed 12/15/2025
ID Prefix A1073 Reg. # 8:36-15.6(b) LSC	Correction Completed 01/09/2026	ID Prefix A1095 Reg. # 8:36-16.5(b) LSC	Correction Completed 12/15/2025	ID Prefix A1097 Reg. # 8:36-16.6 LSC	Correction Completed 12/15/2025
ID Prefix A1183 Reg. # 8:36-17.2(a) LSC	Correction Completed 12/15/2025	ID Prefix A1249 Reg. # 8:36-17.7 LSC	Correction Completed 12/15/2025	ID Prefix A1309 Reg. # 8:36-18.4(a)(2) LSC	Correction Completed 01/09/2026

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	
10/16/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO