STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01A000	A. BUILDING: _____ B. WING _____	C 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT BRANDALL ESTATES	432 CENTRAL AVENUE LINWOOD, NJ 08221

(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: COMPLAINT #: NJ172499, NJ172692, NJ183200 CENSUS: 75 SAMPLE SIZE: 10 TYPE OF SURVEY: Standard Survey of 100 residential units The facility is not in substantial compliance with all 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 Life Safety Code Survey was conducted by the State Agency on 11/17/2025. The facility was not in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs.	A 000		
A 761	8:36-7.4(a) Resident Assessments and Care Plans (a) The assisted living residence, comprehensive personal care home, or assisted living program shall ensure that the resident receives "health care services" under the direction of a registered professional nurse, in accordance with the health service plan.	A 761		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/23/25

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 761	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and document review, the facility failed to ensure staff implemented the individual service plan for 1 (Resident #1) of 10 sampled residents. Findings included: A "Resident Face Sheet" revealed the facility admitted Resident #1 on NJ Exec Order 26.4b1. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of NJ Exec Order 26.4b1 Resident #1's "Individual Service Plan," dated NJ Exec Order 26.4b1, revealed "Care managers to provide NJ Exec Order 26.4b1 of assistance to resident during NJ Exec Order 26.4b1 including NJ Exec Order 26.4b1 The facility "Investigation Summary" indicated "On NJ Exec Order 26.4b1, at approximately 5:41 pm, an incident occurred in resident apartment [number]. The resident, [Resident #1], was being assisted by aide [Care Manager #1] when [he/she] NJ Exec Order 26.4b1 from [his/her] wheelchair, despite the care plan required a NJ Exec Order 26.4b1 While the aide turned to gather supplies, the resident used [his/her] NJ Exec Order 26.4b1 [himself/herself] into a NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1, NJ Exec Order 26 on [his/her] NJ Exec Or and NJ Exec Order 26.4b1 The Investigation Summary specified, "Resident's care plan required a NJ Exec Order 26.4b1, yet [Care Manager #1] had performed the NJ Exec Order 26.4 [Care Manager #1] admitted to NJ Exec Order 26.4b1 the resident on her own, contrary to the care plan.	A 761		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT BRANDALL ESTATES	432 CENTRAL AVENUE LINWOOD, NJ 08221

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A 761	Continued From page 2 As a result, she was reassigned temporarily, and after a full investigation, her employment was [redacted] on [redacted] for failing to follow the established care plan." During a telephone interview on 11/17/2025 at 1:47 PM, Care Manager #1 confirmed she [redacted] the resident from their [redacted] to their wheelchair [redacted] staff member. During an interview on 11/18/2025 at 12:00 PM, the Executive Director (ED) stated the facility did not have a [redacted] policy, but [redacted] were always done with [redacted] in the facility. During an interview on 11/20/2025 at 12:10 PM, Licensed Practical Nurse #4 stated [redacted] were always a [redacted]. During an interview on 11/20/2025 at 12:12 PM, Care Manager #5 stated [redacted] were always a [redacted]. During a follow-up interview on 11/20/2025 at 12:14 PM, the ED stated there should have been [redacted] in the room if the intention was to [redacted] the resident.	A 761		
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.	A1097		

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BRANDYWINE LIVING AT BRANDALL ESTATES	432 CENTRAL AVENUE LINWOOD, NJ 08221

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A1097	Continued From page 3	A1097		

This REQUIREMENT is not met as evidenced by:
Based on interview and observation, the facility failed to provide fire sprinkler coverage in 2 of 2 bathroom storage closets. This deficient practice had the potential to affect all 75 residents who currently resided in the facility.

Findings included:

During a concurrent observation and interview on 11/17/2025 at 12:53 PM, a bathroom by Room 168 had a storage closet with a door mounted on the closet and the storage closet had no evidence of sprinkler coverage. The Maintenance Director measured the storage closet located inside the bathroom, and it was observed at 5 feet by 2 ½ feet. The Maintenance Director acknowledged there was no sprinkler coverage inside the storage closet.

During a concurrent observation and interview on 11/17/2025 at 1:33 PM, a bathroom by Room 108 had a storage closet with a door mounted on the closet and the storage closet had no evidence of sprinkler coverage. The Maintenance Director measured the storage closet located inside the bathroom, and it was observed at 5 feet by 2 ½ feet. The Maintenance Director acknowledged there was no sprinkler coverage inside the storage closet.

During an interview on 11/17/2025 at 2:24 PM, the Maintenance Director stated he was aware

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A1097	Continued From page 4 that the bathroom storage closets by Room 168 and Room 108 required sprinkler coverage. The Maintenance Director stated he expected the facility to be fully sprinklered, including the storage closets. During an interview on 11/17/2025 at 3:19 PM, the Executive Director (ED) stated the facility renovated the bathrooms approximately six months prior and added storage closets in each of the bathrooms. The ED stated she was aware the storage closets located inside the bathrooms required sprinkler coverage. The ED stated she expected the facility to be fully sprinklered, including the storage closets in the bathrooms. During an interview on 11/17/2025 at 3:57 PM, the Maintenance Director stated the facility did not have a policy on ensuring proper sprinkler protection.	A1097		
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 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.	A1249		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1249	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview, document review, and facility policy review, the facility failed to monthly test 2 of 2 elevators with firefighter's emergency operations during 5 of 24 months. This deficient practice had the potential to affect all 75 residents who currently resided in the facility. Findings included: A facility policy titled, "Elevators," revised 01/01/2021, revealed, "The Maintenance Director will ensure routine inspections are completed and the elevator certifications are up to date." The facility "Work History Report" for the prior 24 months revealed that the monthly elevators firefighter's emergency operation testing was not performed during the months of 11/2023, 12/2023, 01/2024, 04/2024, and 10/2024. During an interview on 11/17/2025 at 2:24 PM, the Maintenance Director stated the facility had two hydraulic elevators with firefighter's emergency operations. The Maintenance Director stated the required monthly testing of the firefighter's emergency operations was not completed during the months of 11/2023, 12/2023, 01/2024, 04/2024, and 10/2024. The Maintenance Director stated he was aware that elevators with firefighter's emergency operations required monthly testing and operation. The Maintenance Director stated he expected the elevators firefighter's emergency operations to be tested and operated monthly. During an interview on 11/17/2025 at 3:17 PM, the Executive Director (ED) stated she was not aware of the requirement to monthly test the	A1249		

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A1249	Continued From page 6 elevators firefighter's emergency operations. The ED acknowledged after looking at documentation for the prior 24 months that the monthly tests were not completed during 11/2023, 12/2024, 01/2024, 04/2024, and 10/2024. The ED stated she expected the elevators to be inspected, tested, and maintained per the life safety code.	A1249		

POC #3 received 1/20/26
Accepted 1/20/26

BRANDYWINE

BRANDALL ESTATES

PLAN OF CORRECTION

Facility: Brandywine Living at Brandall Estates
Address: 432 Central Ave, Linwood, NJ 08221
License Number: 01A000
Survey Date: 11/20/2025
POC Submission Date: 12/23/2025 (Revised January 2026)

St – A – 0761

N.J.A.C. 8:36-7.4(a) – Resident Assessments and Care Plans

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

Response:
Immediately following the identified incident, the facility reviewed **Resident #1's** Individual Service Plan (ISP) and reaffirmed the requirement for a NJ Exec Order 26.4b1 for all NJ Exec Order 26.4b1 The Registered Nurse confirmed the resident's current care needs and ensured the ISP accurately reflected required NJ Exec Order 26.4b1
All direct care staff were re-educated on Resident #1's NJ Ex Order 26.4(b)(1) requirements and the importance of adhering strictly to the ISP. The involved Care Manager was removed from resident care pending investigation and was subsequently NJ Exec Order 26.4b1 for failure to follow the established care plan. Resident #1 continues to receive NJ Exec Order 26.4b1 in accordance with the ISP.

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

Response:
All residents had the potential to be affected by this deficient practice. The Registered Nurse conducted a comprehensive review of all current residents' Individual Service Plans

to identify residents requiring two-person assistance or other specific transfer interventions.

Individual Service Plans are reviewed on an ongoing basis in accordance with facility policy, which requires review at least every six (6) months, or sooner if there is a change in the resident's condition or clinical status. As part of this corrective action, the Registered Nurse reviewed each resident's most current ISP during their scheduled review cycle, or earlier if indicated, to verify transfer requirements and level of assistance.

Any residents identified as requiring two-person assistance had their care plans reviewed and verified at the time of review, and direct care staff were notified of the required level of assistance to ensure compliance and resident safety.

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

Response:
Following the change in ownership on November 1, 2024, the facility implemented a formal Transfer and Mobility Assistance Policy outlining staff responsibilities and required assistance levels during resident transfers.
On January 13, 2025, the Wellness Director conducted mandatory in-service education for direct care staff reinforcing that resident care plans must be followed at all times and that residents requiring two-person assistance may not be transferred by a single staff member.
An outside therapy agency provided additional education on safe transfer techniques. This education was conducted on January 13, 2025, and was coordinated by the Wellness Director to reinforce proper body mechanics, transfer safety, and adherence to resident-specific care plans.

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

Response:
The Registered Nurse will conduct monthly audits of resident transfer practices, ISP

compliance, and incident reports related to transfers. Findings will be addressed promptly through retraining, counseling, or corrective action as indicated.
Audit results will be reviewed as part of the facility's Quality Assurance and Performance Improvement (QAPI) process to ensure sustained compliance and ongoing oversight.

Completion Date: 11/21/2025 [redacted] approved 1/20/26

St – A – 1097

N.J.A.C. 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.

Response:
The facility began developing and implementing a corrective plan on 11/20/2025 following the survey exit conference to address the lack of sprinkler coverage in bathroom storage closets located near Rooms 108 and 168.
As an immediate interim life safety measure, the facility removed the doors from the affected bathroom storage closets to eliminate enclosed spaces requiring sprinkler protection until permanent corrective action could be completed.

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

Response:
All residents had the potential to be affected. The Maintenance Director conducted a facility-wide inspection of all bathrooms, storage closets, and renovated areas to identify any additional enclosed spaces requiring sprinkler protection. No additional non-compliant areas were identified during this review.

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

Response:
The bathroom storage closets cited in the survey were constructed as part of a renovation project completed in mid-2025. During construction, required sprinkler coverage was not installed by the construction contractor in the affected closets, and the omission was not identified by the facility at the time the spaces were placed into use.

The facility maintains an established physical plant and life safety review process for renovations and construction activities. To prevent recurrence, the facility reinforced its review and verification procedures following identification of this deficiency. Life safety compliance, including verification of required sprinkler coverage, is now confirmed prior to occupancy of any newly constructed or renovated space, with documented sign-off by maintenance leadership and administrative oversight by the Executive Director.

The facility coordinated with a licensed fire protection contractor to correct the deficiency. The contractor was contacted on 11/20/2025 for a quote and scheduling of the installation. Sprinkler installation in the affected closets was completed on 1/13/2026, bringing the areas into full compliance.

Since implementation of the reinforced verification process, no additional life safety deficiencies related to sprinkler coverage have been identified.

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

Response:
The Executive Director and Maintenance Director review compliance with monthly inspections and life safety measures on a monthly basis. Environmental safety rounds are conducted at least monthly, with documentation maintained. Contractor coordination, installation records, and final inspection documentation are retained and reviewed to ensure ongoing compliance.

BRANDYWINE

BRANDALL ESTATES

Completion Date: 1/13/2026 (reflects the date all sprinkler-related corrective actions were confirmed as completed)

[redacted] approved 1/20/26

St – A – 1249

N.J.A.C. 8:36-17.7 – Housekeeping, Sanitation, Safety, and Maintenance

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

Response:
The facility completes firefighter's emergency operation testing for both elevators on a monthly basis in accordance with the life safety preventive maintenance schedule. A calendar reminder is generated on the 2nd day of each month to prompt completion of the required testing.

Testing is completed each month following the reminder, documented in the maintenance logs, and verified by the Maintenance Director to ensure proper elevator operation and resident safety.

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

Response:
All residents had the potential to be affected. The Maintenance Director reviewed life safety and maintenance documentation for the prior 24 months to identify any additional lapses in required testing. Any missing or incomplete documentation was corrected.

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

Response:
The facility implemented a life safety preventive maintenance schedule that requires monthly inspection and testing of life safety systems, including firefighter's emergency operation testing for elevators. A recurring calendar reminder is generated on the 2nd day of each month to ensure timely completion and documentation.

Responsibility for completion and documentation is assigned to the Maintenance Director, with oversight by the Executive Director. This process ensures consistent compliance and prevents missed testing.

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

Response:
The Executive Director reviews elevator testing logs monthly, and quarterly audits of life safety systems are conducted to ensure compliance. Any identified issues are addressed promptly through corrective action and staff education.

Completion Date: 11/21/2025

[redacted] approved 1/20/26

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
01A000	A. Building B. Wing	1/20/2026

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT BRANDALL ESTATES	432 CENTRAL AVENUE LINWOOD, NJ 08221

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 A0761 Reg. # 8:36-7.4(a) LSC	Correction Completed 11/21/2025	ID Prefix A1097 Reg. # 8:36-16.6 LSC	Correction Completed 01/13/2026	ID Prefix A1249 Reg. # 8:36-17.7 LSC	Correction Completed 11/21/2025
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 11/20/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			