STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55A007	A. BUILDING: _____ B. WING _____	C 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT THE SYCAMORE	5 MERIDIAN WAY SHREWSBURY, NJ 07702

(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: CENSUS: 71 SAMPLE SIZE: 7 TYPE OF SURVEY: Standard Survey of 106 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 000		
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;	A 517		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/23/26

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 517	Continued From page 1 3. The infection prevention and control program; 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 facility policy review, facility personnel file review, and interview, the facility failed to ensure that an employee orientation checklist form was completed and maintained for 1 (Licensed Practical Nurse [LPN] #1) of 5 personnel files reviewed. Findings included:	A 517		

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A 517	Continued From page 2 A facility policy titled, "Team Member Training," revised 06/02/2022, indicated, "The community will provide new team member orientation and annual on-going training as outlined below per state regulations." The policy's "Procedure" included, "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." The policy revealed, "3. New Team Member Orientation will be documented, and a copy kept in the team member's personnel file, and will include," which revealed, "a. The name and position of the team member," "b. The name and position of the trainer for each section," and "c. The date, time, and location of training." LPN #1's personnel file revealed the facility hired the LPN on NJ Exec Order 26.4b1. The file revealed there was no documented proof that orientation was completed upon hire. During an interview on 12/04/2025 at 5:00 PM, the Business Office Manager (BOM) stated that she had no documentation of the orientation checklist for (LPN #1). During an interview on 12/04/2025 at 6:07 PM, the Health and Wellness Director stated he expected each department to complete the orientation checklist form with the new employees. He stated he expected the orientation checklist form to be signed and given to the BOM when completed. During an interview on 12/04/2025 at 6:10 PM, the Executive Director (ED) stated she expected each department to complete the orientation checklist form with the new employees. The ED stated that she expected the orientation checklist	A 517		

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A 517	Continued From page 3 form to be signed and given to the BOM when completed.	A 517		
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. This REQUIREMENT is not met as evidenced by: Based on New Jersey Administrative Code (NJAC) 8:24, "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines," observation, and interview, the facility failed to ensure food employees effectively wore hair and/or NJ Ex Order 2 restraints, failed to date opened food items in the refrigerator and dry storage areas, and failed to ensure staff completed hand hygiene after becoming contaminated. These deficient practices had the potential to affect all 71 residents who received food from the kitchen. Findings included: 1. Reference: NJAC 8:24-2.4(a)(c)1 indicated, "(c) The following requirements shall apply to hair restraints: 1. Except as provided in (c)2 below,	A 891		

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A 891	Continued From page 4 food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens; and unwrapped single-service and single-use articles." During an observation of the facility's kitchen on 12/03/2025 beginning at 10:15 AM, the Executive Chef, Server #2, Cook #3, and Utility Worker #4 were observed with visible NJ Exec Order 26.4b1 and were not wearing NJ Exec Order 26.4b1. During an observation of the dietary department on 12/04/2025 at 11:35 AM, Server #5 was wearing a hairnet that did not restrain all of her hair. During an interview on 12/04/2025 at 11:37 AM, Server #5 stated she did not realize her hair net did not cover all her hair. 2. Reference: NJAC 8:24-3.3 (z) specified, "(z) Food shall be protected from contamination that may result from a factor or source not specified above." During a continuous observation with the Culinary Supervisor on 12/03/2025, beginning at 10:20 AM, revealed one bag of elbow noodles, one bag of spaghetti noodles, a box of carrot cake mix, a container of chow mein noodles, two sleeves of crackers, one bag of cereal, and one package of taco seasoning mix were in the dry storage area opened and not dated. In a refrigerator was flank steak removed from its original package, bolognese sauce (raw) in a pan covered with plastic, Swiss cheese, and mozzarella cheese were observed opened and undated in the	A 891		

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A 891	Continued From page 5 refrigerator. 3. Reference: NJAC 8:24-2.3(f) indicated, "(f) Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles, and," which included "1. After touching bare human body parts other than clean hands and clean, exposed portions of arms;" "5. After handling soiled equipment or utensils;" "6. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks;" "7. When switching between working with raw food and working with ready-to-eat food;" "Before donning gloves for working with foods;" and "9. After engaging in other activities that contaminate the hands." During an observation on 12/03/2025 at 10:30 AM, Cook #3 donned a beard restraint, opened a trash can lid, donned a pair of gloves, opened a pack of raw brisket, and then used a gloved hand to lift the trash can. Cook #3 encountered multiple surfaces in the dietary department then touched the brisket that he was preparing for the evening meal without completing hand hygiene. The Culinary Service Director (CSD) was notified, who stopped the cook due to cross-contamination. During an interview on 12/03/2025 at 10:38 AM, Cook #3 stated he should have washed his hands after he put the NJ Exec Order 26.4b1 on and after each time he touched the trash can. During an interview on 12/04/2025 at 3:24 PM, the CSD revealed the facility was purchased by another company in NJ Exec Order 26.4b1 and they are	A 891		

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A 891	Continued From page 6 still working to develop policies for food service. The CSD stated he expected all dietary staff and anyone that comes in the kitchen to wear a hair restraint, dietary staff with facial hair to wear a beard restraint, wash their hands after putting on a hair restraint, touching trash can lids or any other possible contaminated surfaces. The CSD further stated he expected all opened food items to be labeled and dated. During an interview on 12/04/2025 at 3:55 PM, the Executive Director (ED) stated she expected all opened food items to be labeled and dated, dietary staff and anyone that comes in the kitchen to secure all hair with a hair restraint and/or NJ Ex Order 2 restraint, and staff to wash their hands after they are contaminated by touching soiled surfaces or food.	A 891		
A 537	8:36-5.7(a)(1) Policy and Procedure Manual (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following: 1. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and resident care services of the facility or program;	A 537		

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A 537	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to maintain an updated maintenance and housekeeping policy and procedure. This deficient practice was evidenced by the following: On 12/3/25 at 10:53 a.m., the surveyor reviewed the maintenance and housekeeping procedure manual provided by the Director of Environmental Services (DES). The surveyor observed that the maintenance and housekeeping procedure manual was last revised on 1/1/2022. At 11:00 a.m., the surveyor interviewed the DES regarding the outdated maintenance and housekeeping procedure manual. The DES stated that corporate came in annually to review the policies, however the manual did not reflect the correct date.	A 537		
A1097	8:36-16.6 Fire Suppression Systems 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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A1097	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain two sprinkler heads on the second floor. This deficient practice was evidenced by the following: On 12/3/25 at 9:50 a.m., the surveyor toured the common areas of the facility with the Director of Environmental Services (DES). The surveyor observed a sprinkler head by room [redacted] with a large gap at the base of the sprinkler. Additionally, the surveyor observed another sprinkler without a cap by room [redacted] At 9:55 a.m., the surveyor interviewed the DES regarding the sprinklers. The DES stated that he was unaware of the issues and will address them.	A1097		
A1193	8:36-17.3(a)(4) Resident Environment (a) The housekeeping and sanitation conditions in paragraphs 1 through 12 below shall be met. Application of this requirement with respect to the individual living environment shall take into consideration residents' personal preferences for style of living: 4. All furnishings shall be clean and in good repair, and mechanical equipment shall be in working order. Items which are broken or worn to	A1193		

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A1193	Continued From page 9 the extent that they may cause discomfort or present danger to residents shall be repaired, replaced, or removed promptly; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain clean appearance of the ceiling and ceiling tiles. This deficient practice was evidenced by the following: On 12/3/25 at 9:50 a.m., the surveyor toured the common areas with the Director of Environmental Services (DES). The surveyor observed a ceiling tile and an area of the ceiling above the door in the library had visible stains. At 9:55 a.m., the surveyor observed a water leak at the base of a toilet in a public restroom on the first floor accross from the library. At 10:04 a.m. in a public restroom on the second floor, the surveyor observed a ceiling tile with water stains. At 10:11 a.m., the surveyor interviewed the DES regarding the stains on the ceiling tiles the water leak at the base of the toilet. The DES acknowledged the above concerns and stated that he would address them.	A1193		

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A1249	Continued From page 10	A1249		
A1249	8:36-17.7 Building and Grounds 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to maintain the exterior exit door in the dinning room, the vertical sprinkler pipe in stairwell 2 on the first floor, and a sink in a public bathroom on the second floor. This deficient practice was evidenced by the following: On 12/3/25 at 11:50 a.m., the surveyor toured the facility in the presence of the Director of Environmental Services (DES). The surveyor observed the exterior exit door of the dining room on the first floor not latching properly. Additionally, the surveyor observed a crack at the top of the door frame by the latching mechanism which prevented the door from properly latching. At 11:56 a.m., the surveyor observed a gap in the ceiling around the vertical sprinkler pipe.	A1249		

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A1249	Continued From page 11 At 12:03 p.m., the surveyor observed a sink in a public restroom on the second floor near the elevator that was not draining properly. At 12:10 p.m., the surveyor interviewed the DES regarding the exterior exit door, the ceiling and the sink. The DES stated that he would address the above concerns.	A1249		

POC #3 received 2/5/26
Approved 2/6/26

BRANDYWINE

THE SYCAMORE

February 2, 2026

A517

1) **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
Residents were affected by the deficient practice related to LPN #1 not receiving documented orientation upon hire. LPN#1 will be provided training on the required orientation topics including Assisted Living Philosophy, Emergency Plans and Procedures, Infection control prevention and control, Residents Rights, Abuse and neglect, Pain management, and Care of residents with Alzheimer's disease and related dementias. Completed 12/9/2025.
2) **How the facility will identify other residents having the potential to be affected by the same deficient practice:**
All the residents, at any given time, have the potential to be affected by the deficiency.
3) **What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur:**
Effective 12/8/2025, Orientation Checklist must now be completed by the Business Office Manager, signed by the department heads and the Executive Director.
4) **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:**
Effective 12/8/2025, all newly hired employees are provided with orientation upon hire prior to working independently, and orientation completion is documented and maintained in the employee's personnel file. This will be monitored by the Business Office Manager.
Effective 12/8/2025, Business Office Manager and the Executive Director will audit new hire files monthly.
Starting 12/8/2025, The Executive Director will monitor these weekly audits to ensure ongoing compliance and will review findings during the quarterly Quality Assurance and Quality Improvement Meetings. Effective 12/8/2025, any identified issues will be addressed immediately. Completed 12/9/2025.

Approved 2/6/26

A891

1) **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
All residents are affected by this deficient practice. On 12/3/2025, the Director of Culinary services conducted an immediate corrective action by educating the dietary staff on the importance of using hair nets and [NJ Ex Order 26.4(b)(1)] and hygiene, and food labeling. Completed on 12/5/2025
2) **How the facility will identify other residents having the potential to be affected by the same deficient practice:**
All the residents have the potential to be affected by the deficient practice related to Infection Control in the Dietary Department.
3) **What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur:**
Effective 12/05/2025, the Director of Culinary Services implemented daily monitoring and reminders, and monthly education to dietary staff regarding infection control practices, including proper hand hygiene, use of hair and beard restraints, and food handling procedures. Completed on 12/5/2025.
4) **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:**
Effective 12/5/2025, the Director of Culinary Services or Designee will conduct daily observations. The Executive Director completes monthly kitchen audits documenting any findings. This audit will be included in the quarterly Quality Assurance/ Quality Improvement meeting for three quarters for evaluation of the effectiveness of the above plan of correction. Completed 12/5/2025.

approved 2/10/26

A537

1) **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
All residents are affected by the deficient practice related to outdated Environmental Services policies and procedures. On 12/3/2025, an updated housekeeping and maintenance policy and procedure was received from the corporate office. On 12/3/2025 a copy was provided to the surveyor. On 12/05/2025 the updated policy and procedure was reviewed, signed and dated by the Executive Director and Environmental Service Director and placed in the Facility's Policy and

Procedure Manual. The Policy and Procedure was reviewed, signed and dated by all Department Heads and completed on 12/10/2025.

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

All the residents, at any given time, have the potential to be affected by the deficient practice related to outdated maintenance and housekeeping policy and procedure.

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

Effective 12/05/2025, the Executive Director and the Environmental Services Director will ensure that all housekeeping and maintenance policies and procedures are reviewed, updated and signed by the appropriate department heads. This process ensures that current policies are in place and consistently followed, reducing the potential for residents to be affected by outdated policies and procedures. The deficiency was corrected and completed on 12/5/2025.

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

Effective 12/5/2025 the Executive Director will conduct a monthly audit to ensure all housekeeping and maintenance policies and procedures are current, updated and properly signed. Policy review and compliance will be discussed during the quarterly Quality Assurance/Quality Improvement meetings and documented to ensure continued effectiveness of the corrective actions and to prevent recurrence of the deficient practice. Completed 12/5/2025.

[redacted] approved 2/6/26

A1097

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

All residents are affected by the deficient practice related to sprinkler escutcheons. On 12/3/2025, the issue was addressed immediately by the Environmental Service Director. The sprinkler escutcheon gap outside apartment 229 was caulked, and the sprinkler escutcheon outside apartment 230 was replaced prior to the surveyor leaving the facility. Photographic documentation was obtained and submitted to the surveyor on 12/3/2025 to verify completion of the corrective action. The deficiency was corrected and completed on 12/5/2025.

2) **How the facility will identify other residents having the potential to be affected by the same deficient practice:**
All the residents, at any given time, have the potential to be affected by the deficient practice as referenced.

3) **What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur:**
Effective 12/5/2025, the Environmental Service Director or designee will conduct monthly inspections of sprinkler heads and fire suppression components and ensures corrective action is taken immediately when deficiencies are identified. Documentation will be provided to the Executive Director. Monitoring results are documented and reviewed monthly by the Executive Director.

4) **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:**
Effective 1/23/2026, monthly monitoring of results will be documented and reviewed by the Executive Director. Policy review and compliance will be discussed during quarterly Quality Assurance/Quality Improvement meetings and documented to ensure continued effectiveness of the corrective actions and to prevent recurrence of the deficient practice. Completed 1/23/2026.

A1193 [redacted] approved 2/6/26

1) **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
All residents were affected by the deficient practice related to the appearance and condition of the ceiling tiles and plumbing in common and public areas. On 12/5/2025 the Environmental Services Director repaired the water leak at the base of the toilet, addressing the source of the moisture and replaced the ceiling tiles in the library and public restrooms to restore a clean and safe environment for the residents. On 12/5/2025 The tiles were replaced by the Assistant to the Environmental Services Director. Both Deficiencies were corrected and completed by 12/5/2025.

2) **How the facility will identify other residents having the potential to be affected by the same deficient practice:**
All the residents, at any given time, have the potential to be affected by the deficient practice as referenced.

3) **What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur:**
Effective 12/5/2025 The Environmental Service Director or Designee implemented weekly rounds and reminders, and monthly education to staff regarding prompt identification and repair of water leaks, ceiling damage and other environmental concerns. Completed 12/5/2025.

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

Effective 1/23/2026, the Environmental Service Director will conduct a monthly routine environmental inspection of common areas and public restrooms. Findings will be documented, and any concerns will be addressed promptly. Monitoring results will be reviewed monthly by the Executive Director and discussed during the quarterly Quality Assurance/Quality Improvement meetings to ensure continued compliance and effectiveness of corrective actions. Completed 1/23/2026

A1249 [redacted] approved 2/6/26

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

All residents were affected by the deficient practice related to building and grounds maintenance. On 12/3/2025, the sink in the public restroom on the second floor by the elevator was addressed by the Environmental Service by pushing the drain stopper closed, then once the stopper opened, water drained properly. On 12/5/2025, the dining room exterior door closing and latching were repaired and the crack at the top of the door frame was caulked and secured. Both deficiencies were corrected and completed on 12/5/2025.

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

All the residents, at any given time, have the potential to be affected by the deficient practice as referenced.

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

Effective 12/5/2025 The Environmental Service Director or Designee will conduct weekly inspections of building components, including exterior doors, fire safety elements, ceilings, and plumbing systems, to identify any additional maintenance concerns that could impact resident safety. Completed 12/5/2025.

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

Effective 1/23/2026, the Environmental Service Director or designee will conduct a weekly routine inspections and document findings.

Effective 1/23/2026 the Executive Director will review or monitor maintenance compliance and trends every month to ensure maintenance concerns are addressed in a timely manner.

Effective 1/23/2025 results of the audit will be discussed during the quarterly Quality Assurance/Quality Improvement meetings to ensure continued compliance and effectiveness of corrective actions. Completed 1/23/2025.

[redacted] approved 2/6/26

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
55A007 (Y1)	A. Building B. Wing (Y2)	2/6/2026 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT THE SYCAMORE	5 MERIDIAN WAY SHREWSBURY, NJ 07702

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 A0517 Reg. # 8:36-5.6(b)(1-7) LSC	Correction Completed 12/09/2025	ID Prefix A0891 Reg. # 8:36-10.5(a) LSC	Correction Completed 12/05/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	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 12/4/2025	☐ 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
55A007 Y1	A. Building B. Wing Y2	2/6/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT THE SYCAMORE	5 MERIDIAN WAY SHREWSBURY, NJ 07702

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 A0537	Correction	ID Prefix A1097	Correction	ID Prefix A1193	Correction
Reg. # 8:36-5.7(a)(1)	Completed	Reg. # 8:36-16.6	Completed	Reg. # 8:36-17.3(a)(4)	Completed
LSC	12/05/2025	LSC	01/23/2026	LSC	01/23/2026
ID Prefix A1249	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.7	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/23/2026	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
12/4/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO