STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80a005	A. BUILDING: _____ B. WING _____	C 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT MOUNTAIN RIDGE	680 MOUNTAIN BOULEVARD WATCHUNG, NJ 07069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Type of Survey: Complaint/FRE Complaint #: NJ00189516 Census: 68 Sample Size: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administrator's Responsibilities (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/02/26

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 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00189516

Based on interview, record review, and review of other pertinent facility documents, the facility failed to: a.) ensure the implementation of the facility's policies and procedures titled, "Executive Director/Designee Responsibilities (HR302-NJ)," "Elopement/Missing Resident (HW503)," and "Resident Incident Reports (HW508)," and b.) ensure that a thorough investigation was completed following an NJ Exec Order 26.4b1 incident involving 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On NJ Exec Order 26.4b1, the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE indicated that on NJ Exec Order 26.4b1 at approximately 3:50 p.m., Resident #2, who resided in the NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1. During the activity, Resident #2 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 through the NJ Exec Order 26.4b1 at approximately 3:50 p.m. Resident #2 was later NJ Exec Order 26.4b1, who contacted the NJ Exec Order 26.4b1. Resident #2 was returned to the facility by NJ Exec Order and assessed upon return with NJ Exec Order 26.4b1 noted.

On 12/18/25, the surveyor reviewed the Medical Record (MR) for Resident #2 which revealed an

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A 310	Continued From page 2	A 310		

admission date of [redacted] and diagnoses that included NJ Exec Order 26.4b1 and [redacted]. Review of the Care Plan revealed no interventions for [redacted] or [redacted]

At 11:56 a.m., the surveyor interviewed a Care Manager (CM) who stated she was working in the MCU on the date of the incident but was not assigned to Resident #2. The CM stated that the Life Enrichment Coordinator (LEC) [redacted] She remained on the [redacted] to assist the three residents [redacted]

At 12:21 p.m., the surveyor interviewed the LEC regarding the incident involving Resident #2. The LEC stated that she was working on the day of the incident and was training a new employee. The LEC added that she escorted 15 residents from [redacted] to the [redacted] for the scheduled event. The LEC further stated that she did not know that Resident #2 had NJ Exec Order 26.4b1 and explained that the [redacted] was busy with residents and vendors from the [redacted] and Assisted Living. The LEC explained that she was asked by the Life Enrichment Director (LED) to cover the concierge break while training a new Life Enrichment Assistant (LEA). The LEC stated that two LEA assistants began NJ Exec Order 26.4b1 and that she did not know which residents were [redacted] to the unit. The LEC further stated that after [redacted] residents to the [redacted] she returned to the front desk to continue training the LEA, at which time police contacted the facility to inquire if a resident was [redacted]

At 1:49 p.m., the surveyor interviewed a Registered Nurse (RN) via telephone regarding the incident involving Resident #2. The RN stated

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A 310	Continued From page 3	A 310		

that she was working on the [NJ Exec Ord] on the day of the incident and that the LEC escorted residents from the [NJ Exec Ord] to the [NJ Exec Ord] for a scheduled activity. The RN further stated that she also remained at the [NJ Exec Ord] with the three residents who did not attend the activity. The RN added that she did not direct the CM to accompany residents to the [NJ Exec Ord] and was not aware that Resident #2 had NJ Exec Order 26.4b1 when she was notified that the resident was [NJ Exec Order 26.4b]

At 2:00 p.m., during a follow up interview with the CM, via telephone, the CM stated that she was working on the [NJ Exec Ord] on the day of the incident and that her shift started at 3:00 p.m. The CM stated that she asked the RN where the residents were upon her arrival to the unit and was told that the residents were at an activity. She further stated that she did not go to check on her assigned residents.

At 3:30 p.m., the surveyor interviewed the Executive Director (ED) regarding the incident involving Resident #2. The ED stated that she was not present, in the facility, at the time of the incident, although she was scheduled as the Manager on Duty (MOD). The ED added that she left the facility prior to the scheduled activity and was not aware that the activity was occurring. The ED stated that she conducted an internal investigation by collecting written statements from Life Enrichment staff who hosted the activity and by interviewing the LEC that escorted the residents off the [NJ Exec Order] The ED further stated that she did not interview nursing staff working on the [NJ Exec Ord] at the time of the incident and that the LEC was responsible for ensuring that Resident #2 returned to the [NJ Exec Ord] safely.

The surveyor reviewed facility documents titled,

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A 310	Continued From page 4 "Continuing Education Inservice," which revealed that NJ Exec Order 26.4b1 drills were conducted on 5/14/25 and 7/25/25. The records did not reveal that NJ Ex Order 26.4(b)(1) drills were conducted at least once quarterly for all shifts, as required by facility policy. The surveyor review of a facility policy, dated last revised 01/01/2021, titled," Executive Director/Designee Responsibilities (HR302-NJ)," which revealed, ..." Procedure: 1. The ED or Designee will be responsible for, but not limited to, the following: a. Ensuring the development, implementations, and enforcement of all policies and procedures, including resident rights." The surveyor review of a facility policy, dated last revised 11/28/2023, titled, "Elopement/Missing Resident (HW503)" which revealed: "Policy: The community will ensure residents who are at risk for elopement are identified and that the proper interventions are implemented to minimize elopement opportunities ...Identification & Intervention Procedures ...3. The resident's service plan will identify if the resident is determined to be at risk for elopement and interventions to minimize risk will be included in the service plan... Elopement Procedures: ...16. All shifts will participate in an elopement drill at least once quarterly lead by the Maintenance Director utilizing the Elopement/Missing Resident form..." The surveyor review of a facility policy, dated last revised 07/24/2023, titled, "Resident Incident Reports (HW508)", which revealed: ..." Procedure ...8 ...Timely and accurate reporting to state specific agencies will occur as required by state regulations..."	A 310		

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A 357	Continued From page 5	A 357		
A 357	8:36-4.1(a)(2) Resident Rights (a) Each assisted living provider shall post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 2. The right to receive a level of care and services that addresses the resident's changing physical and psychosocial status; This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of other pertinent facility documents, it was determined that the facility failed to provide NJ Exec Order 26.4b1 for a NJ Exec Order 26.4b1 resident during a NJ Exec Order 26.4b1. The deficient practice was identified for Resident #1, 1 of 3 residents reviewed and was evidenced by the following: On NJ Exec Order 26.4b1 the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE indicated that on NJ Exec Order 26.4b1 at approximately 3:50 p.m., Resident #2, who resided in the NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1. During the activity, Resident #2 NJ Exec Order 26.4b1 from the group	A 357		

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A 357	Continued From page 6	A 357		

and NJ Exec Order 26.4b1 at approximately 3:50 p.m. Resident #2 was later NJ Exec Order 26.4b1 who contacted the NJ Exec Order 26.4b1. Resident #2 was returned to the facility by NJ Exec Order and assessed upon return with NJ Exec Order 26.4b1 noted.

On 12/18/25, the surveyor review of the Medical Record (MR) for Resident #2 which revealed an admission date of NJ Exec Order 26.4b and diagnoses that included NJ Exec Order 26.4b1. Review of the resident's Care Plan revealed no documented interventions addressing NJ Exec Order 26.4b1

At 12:21 p.m., the surveyor interviewed the Life Enrichment Coordinator (LEC) regarding the incident involving Resident #2. The LEC stated that she was working on the day of the incident and was training a new employee. The LEC added that she NJ Exec Order 26.4b1 15 residents from NJ Exec Ord to the NJ Exec Ord for the scheduled event. The LEC further stated that she did not know that Resident #2 had NJ Exec Order 26.4b1 and explained that the NJ Exec Ord was busy with residents and vendors from the NJ Exec Ord and Assisted Living. The LEC explained that she was asked by the Life Enrichment Director (LED) to cover the concierge break while training a new Life Enrichment Assistant (LEA). The LEC stated that two LEA assistants began escorting residents back to the NJ Exec Ord and that she did not know which residents were NJ Exec Order 26.4b1 back to the unit. The LEC further stated that after NJ Exec Order 26.4b1 residents to the NJ Exec Orde she returned to the front desk to continue training the LEA, at which time NJ Exec Order 26.4b1 the facility to inquire if a resident was NJ Exec Order 26.4b

At 1:49 p.m., the surveyor interviewed a Registered Nurse (RN) via telephone that was

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A 357	Continued From page 7	A 357		

working on the NJ Exec Ord the day of the incident and she stated that she remained on the NJ Exec Ord with three residents who did not attend the activity. She further stated that she did not direct the Care Managers (CM) to accompany residents attending the activity.

At 2:00 p.m., the surveyor interviewed with the CM, via telephone, that was working on the NJ Exec Ord the day of the incident. The CM stated that her shift started at 3:00 p.m and that she asked the RN where the residents were, upon her arrival to the unit. The RN informed her that the residents were at an activity. The CM further stated that she did not go to check on her assigned residents.

Review of a facility document dated NJ Exec Order 26.4b1, titled "Resident NJ Exec Order 26.4b1 List," revealed that Resident #2 was not listed on the "Resident NJ Exec Order 26.4b1 List" posted at the front entrance.

At 2:20 p.m., the surveyor interviewed the Director of Health and Wellness (DHW) and inquired whether she was aware that Resident #2 was not listed on the "Resident NJ Exec Order 26.4b1 List." The DHW stated that she was not aware. After reviewing the document with the surveyor, the DHW stated that she would speak with the Concierge, who was responsible for updating the list.

The surveyor review of the facility policy dated last revised 01/01/2021, titled "Assignments (HW302)", revealed the following: Policy: "The Health & Wellness Director (HWD) or designee is responsible for assigning the Health & Wellness team members a list of the residents they are responsible for delivering customized care for during their shift, and what services are to be

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A 357	Continued From page 8 provided. Procedure ...3. Health & Wellness team members are responsible for providing all care and services, as well as any additional duties that may be assigned ..." The surveyor review of a facility policy dated last revised 11/28/2023, titled, "Elopement/Missing Resident (HW503)," revealed, under the Policy section, "The community will ensure residents who are at risk of elopement are identified and that proper interventions are implemented to minimize elopement opportunities..."	A 357		
A 749	8:36-7.3(a) General and Health Service Plans (a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00189516 Based on interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to ensure the Individual Service Plan (ISP) was developed, implemented, and revised to address identified needs for 1 of 3 residents reviewed, Resident #2.	A 749		

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A 749	Continued From page 9 This deficient practice was evidenced by the following: On NJ Exec Order 26.4b1, the New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The FRE indicated that on NJ Exec Order 26.4b1 at approximately 3:50 p.m., Resident #2, who resided in the NJ Exec Order 26.4b1), was escorted to the NJ Exec Order 26.4b1 . During the activity, Resident #2 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 Resident #2 was NJ Exec Order 26.4b1 , who contacted the NJ Exec Order . Resident #2 was returned to the facility by NJ Exec Order and assessed upon return with NJ Exec Order 26.4b1 noted. On 12/18/25, the surveyor reviewed the Medical Record (MR) for Resident #2 which revealed diagnoses that included NJ Exec Order 26.4b1 and NJ Exec Order 26.4 Review of the resident's ISP, as available at the time of survey review, revealed no documented interventions addressing NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 risk. At 2:20 p.m. on 12/18/25, the surveyor interviewed the Director of Nursing (DON). The DON confirmed that Resident #2 did not have ISP interventions in place related to NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 risk at the time of the incident. On 12/18/25, surveyor review of the FRE documentation, dated NJ Exec Order 26.4b1, which revealed that interventions to prevent recurrence were documented following Resident #2's NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 incident. The FRE documented that residents were not permitted to leave the unit unless accompanied by a family member or a	A 749		

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A 749	Continued From page 10 nurs and that residents NJ Exec Order 26.4b1 were required to be NJ Exec Order 26.4b1 by two staff members. On 12/18/25, the surveyor reviewed Resident #2's ISP, as available at the time of survey review. The ISP did not include the interventions documented in the FRE. The surveyor review of a facility policy dated last revised 11/28/2023, titled, "Elopement/Missing Resident (HW503)," revealed, under the Policy section, "The community will ensure residents who are at risk of elopement are identified and that proper interventions are implemented to minimize elopement opportunities ..."	A 749		
A1051	8:36-15.2 Record Availability The records required by this subchapter shall be maintained for all residents and shall be kept available on the premises for review at any time by representatives of the Department. This REQUIREMENT is not met as evidenced by: Complaint # NJ00189516 Based on interview and record review, it was determined that the facility failed to ensure that full access to the Electronic Medical Records (EMRs) was available for review, upon entrance, to the surveyor for 3 of 3 residents reviewed, Residents #1, #2, and #3. This deficient practice was evidenced by the following:	A1051		

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A1051	Continued From page 11 On 12/18/25 at 9:20 a.m., during the entrance conference, the surveyor requested full access to the facility's Electronic Medical Records (EMRs). At that time, the Executive Director (ED) stated that she would be able to provide the surveyor with full access to the EMRs. At 9:45 a.m., the surveyor asked the ED about the login information. The ED stated that she sent an email to the surveyor with the login information. The surveyor attempted to log in using the username provided, but the system prompted the surveyor to input a password. At 10:00 a.m., the surveyor informed the ED that the login was not working. The ED instructed the surveyor to attempt logging in again using a document titled "3rd Party State Surveyor Resource Guide." The surveyor reviewed the document and attempted to log in; however, access was still not obtained. When the surveyor informed the ED that they were still unable to access the residents' records, the ED stated that she would contact Information Technology (IT) to request a new password. The ED later provided the surveyor with a new password, and the surveyor was able to log into the system. However, when the surveyor attempted to enter resident names, the system displayed "no residents," and access to resident medical records was not available. The ED stated that this was not the first time this issue had occurred and that she would contact IT and corporate. At 10:27 a.m., the ED informed the surveyor that IT would contact the surveyor directly by email for troubleshooting.	A1051		

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A1051	Continued From page 12 At 11:35 a.m., the surveyor followed up with the ED regarding access to the EMRs. The ED stated that she would contact IT again and confirmed that corporate was aware of the issue. At 1:20 p.m., the surveyor notified the ED that access to the EMRs remained unavailable. The ED stated that she had contacted IT multiple times and did not know how to resolve the issue. At 1:27 p.m., the surveyor informed the ED that access to the EMRs was still not functional and that the system continued to display no current residents. The surveyor was not granted full access to the EMRs for the survey.	A1051		

BRANDYWINE by MONARCH COMMUNITIES

PLAN OF CORRECTION
Complaint #: NJ00189516

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

1. **Corrective action for residents affected:**
   Resident #2 was assessed on [redacted] by RN on duty upon return to the community with [redacted] noted. Following the elopement incident, Resident #2 was reassessed for [redacted] and [redacted] risk by Health and Wellness Director. Reassessment completed [redacted]. The Individual Service Plan (ISP) was updated to include specific [redacted] interventions, including [redacted], staff [redacted] requirements, and [redacted]. The resident was added to the community's [redacted] List posted at the front entrance. Resident #2 currently resides in the community.

The Executive Director initiated the investigation on 12/14/2025. Following the survey on 12/18/2025, a more comprehensive investigation was conducted on 12/19/2025 by the Executive Director, in collaboration with the Health and Wellness Director, which included interviews with nursing, life enrichment, and care staff to ensure a thorough understanding of the event.

2. Identification of other residents at risk:
All memory care residents were identified as at risk due to the deficient practice.

3. Systemic changes implemented:

All Memory Care Unit (MCU) residents were reassessed on 12/19/2025 for wandering and elopement risk by the Nurse on the unit. The Wandering/Elopement Risk List was audited and updated to ensure accuracy by the Health and Wellness Director on 12/19/2025. Each resident's ISP was reviewed by Health and Wellness Director on 12/19/2025 to confirm that appropriate elopement interventions were documented when indicated.

The facility implemented the following systemic changes:

- A new sign-in/sign-out tracking system for all Memory Care residents leaving the unit was created and implemented by the Executive Director on 12/19/2025.
- If more than half of MCU residents leave the unit as a group, a minimum of two staff members must accompany them.
- A licensed nurse must be notified and approve resident removal from the MCU prior to departure.

- Elopement drills are now conducted twice per month, covering two different shifts each month to ensure all three shifts receive quarterly drill participation.
- Re-education was provided to all department heads and supervisory staff regarding Administrator/Designee responsibilities, investigation requirements, and enforcement of policies including HW503 (Elopement/Missing Resident) and HW508 (Resident Incident Reports) by Executive Director 12/19/2025.
- Manager on Duty (MOD) coverage expectations were clarified by Executive Director on 12/19/2025 to ensure on-site leadership awareness of scheduled activities and unit movement.

4. Monitoring to ensure ongoing compliance:
The Executive Director and Director of Health & Wellness (DHW) started the following on 1/1/2026

- Audit the Wandering/Elopement Risk List weekly for 4 weeks, then monthly thereafter through December 2026.
- Audit 5 random MCU ISPs monthly for documented elopement interventions when applicable through December 2026.
- Review elopement drill documentation monthly to ensure compliance with frequency and shift requirements through December 2026.
- Review all incident investigations to ensure comprehensive documentation and interdisciplinary interviews through December 2026.

5. Completion Date: 1/1/2026

Findings will be reviewed at quarterly Quality Assurance and Performance Improvement (QAPI) meetings for ongoing oversight with review by the Regional Director of Operations and Wellness.

A357 – 8:36-4.1(a)(2) Resident Rights

1. Corrective action for resident affected:
Resident #2's NJ Exec Order 26.4b1 needs were reassessed by facilities Health and Wellness Director NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 interventions were added to the ISP. Staff were re-educated on NJ Exec Order 26.4b1 requirements for NJ Exec Order 26.4b1 residents during off-unit activities by Executive Director and Health and Wellness Director on NJ Exec Order 26.4b1. Resident #2 currently resides in the community.

2. Identification of other residents at risk:
All memory care residents were identified as at risk due to the deficient practice.

3. Systemic changes implemented:

All residents in the MCU were reassessed by facilities Health and Wellness Director 12/20/2025 for supervision needs during activities. Assignments were reviewed to ensure staff accountability for

residents during transitions and group activities by Health and Wellness Director on 12/20/2025, including:

- Clear staff assignment accountability during off-unit activities.
- Mandatory documented headcounts before departure, during activities, and upon return to the unit.
- Documentation regarding which staff member escorts specific residents.
- Nurse approval required prior to MCU resident departure.

4. Monitoring plan:
The HWD or designee started the following on 1/1/2026

- Observe at least one off-unit activity weekly for 4 weeks, then monthly through December 2026.
- Audit headcount documentation weekly for 30 days, then monthly through December 2026.
- Address non-compliance through corrective counseling if indicated.

Oversight will occur through QAPI review with secondary review by Regional Director of Operations and Wellness.

5. Completion Date: 1/1/2026

A749 – 8:36-7.3(a) Service Plans

1. Corrective action for resident affected:
Resident #2's ISP was revised by the Health and Wellness Director [redacted] to reflect [redacted] and [redacted] risk, including [redacted] level, [redacted] requirements, and [redacted] interventions. Resident #2 currently resides in the community.

2. Identification of other residents at risk:
All memory care residents were identified as at risk due to the deficient practice.

3. Systemic changes implemented:

A full audit of all MCU ISPs was completed on 12/22/25 by Health and Wellness Director to ensure elopement risks and interventions were accurately documented by facilities Health and Wellness Director.

- Reeducation of a standardized Elopement Risk Assessment tool upon admission, quarterly, and with change in condition done by Regional Director of Health and Operations on 12/22/25 to all Nursing staff. Which includes the following:
    - ISP review checklist requiring verification of wandering/elopement documentation.

- Nursing leadership re-education by Regional Director of Nursing 12/22/2025 on timely ISP updates following incidents and FRE submissions.

4. Monitoring plan started on 12/19/25:

- Monthly audit of 5 ISPs for 3 months, then quarterly through December 2026 review and monitored by the Regional Director of Operations and Wellness during monthly visit.
- Review of all FRE events to ensure ISP updates are completed within 72 hours of incident reviewed by the Regional Director of Operations and Wellness.
- Results tracked and discussed at QAPI meetings with review by the Regional Director of Operations and Wellness.

5.Completion Date: 12/30/25

A1051 – 8:36-15.2 Record Availability

1. Corrective action: The EMR access process was reviewed by the corporate team in collaboration with the IT department 12/19/2025 to ensure surveyor access can be established efficiently. Updates were made to streamline the process and improve accessibility for future surveys. The Corporate team will monitor compliance with this process and provide oversight to ensure appropriate EMR access can be established when needed. Resident #1 currently resides in the community. Resident #2 currently resides in the community. Resident #3 currently resides in the community.

2. Identification of other potential issues:
All memory care residents were identified as at risk due to the deficient practice.

3. Systemic changes implemented:

The facilities corporate team conducted testing of surveyor-level access credentials to ensure full functionality 12/19/25. Corporate IT reviewed system permissions and access pathways to prevent recurrence on 12/19/2025 including the following:

- IT collaboration to streamline search functionality and ensure resident census visibility.
- ED and designee training on immediate EMR access troubleshooting procedures. Regional Director of Operations provided training 12/22/25

4. Monitoring plan:

- Quarterly survey readiness audit conducted by Regional Director of Operations and Wellness on 1/7/26 and ongoing.

- Immediate escalation to IT and corporate compliance if any access issues occur conducted by Executive Director is ongoing.

Results will be reviewed in QAPI for ongoing compliance April 2026.

5. **Completion Date:** 1/7/26

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
80a005 Y1	A. Building B. Wing Y2	3/20/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT MOUNTAIN RIDGE	680 MOUNTAIN BOULEVARD WATCHUNG, NJ 07069

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A0357	Correction	ID Prefix A0749	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(2)	Completed	Reg. # 8:36-7.3(a)	Completed
LSC	01/01/2026	LSC	01/01/2026	LSC	12/30/2025
ID Prefix A1051	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-15.2	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/07/2026	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/18/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
80a005 Y1	Y2	3/20/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE LIVING AT MOUNTAIN RIDGE	680 MOUNTAIN BOULEVARD WATCHUNG, NJ 07069

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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	
12/18/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO