STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12A040	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD AT PRINCETON	1 HOSPITAL DRIVE PLAINSBORO, NJ 08536

(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 #: NJ 00188490 CENSUS: 112 SAMPLE SIZE: 6 TYPE OF SURVEY: Standard Survey of 130 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 361	8:36-4.1(a)(4) Resident Rights (a) Each assisted living provider will 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: 4. The right to be treated with respect, courtesy, consideration and dignity; This REQUIREMENT is not met as evidenced	A 361		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/08/26

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A 361	Continued From page 1 by: Based on observation, interview, and facility document review, the facility staff failed to provide respect and dignity when entering 1 (Room [redacted] of 130 resident rooms. Specifically, the facility failed to ensure staff knocked, introduced themselves, and requested permission to enter Resident Room #[redacted] Findings included: During an interview on 11/04/2025 at 2:00 PM, the Executive Director (ED) stated the facility did not have a policy related to the knocking or asking permission to enter a resident's room. An untitled and undated facility staff orientation document indicated that "When entering an apartment, demonstrate respect by first knocking and announcing yourself in a pleasant manner, Allow the resident to respond. Wait 15 seconds before knocking again and entering the apartment. Once you open the door, please announce yourself again and ask permission to enter 'May I come in?' In certain cases, of course, our residents may not be able to speak or be able to grant us permission to enter. In that case, enter the apartment discreetly and with respect for the resident and their space and belongings. This is their home!" During tour of the facility on 11/03/2025 at 10:25 AM, Home Health Aide (HHA) #7 used a key to enter Resident Room #[redacted] HHA #7 entered the resident's apartment without knocking, introducing herself, or waiting for an invitation to enter. During an interview on 11/03/2025 at 10:29 AM, HHA #7 indicated that she did not knock or	A 361		

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A 361	Continued From page 2 introduce herself when she entered the resident's apartment. HHA #7 stated that out of respect and dignity for the resident, she should have knocked and introduced herself, so the resident knew who was entering their apartment. HHA #7 stated that the resident deserved to be respected, and they had a right to their privacy, and the failure to knock before entering could be violating the resident's privacy. During an interview on 11/04/2025 at 4:32 PM, the Resident Services Director (RSD) stated she expected staff to knock before they entered because it was the resident's home. She also stated that staff should introduce themselves prior to entering and announce their purpose for being there. During an interview on 11/04/2025 at 3:23 PM, the ED stated he expected staff to knock on residents' doors and introduce themselves because it was the residents' home. He also stated that staff should be invited into the resident's apartment, and staff should be polite and respectful.	A 361		
A 475	8:36-5.1(h) General Requirements (h) In accordance with N.J.S.A. 26:2H-12.16 et seq., a new assisted living residence or comprehensive personal care home licensed on or after September 1, 2001, shall attain a level of occupancy by Medicaid-eligible persons of at least 10 percent of its total bed complement within three years of licensure and shall maintain this level of Medicaid occupancy thereafter.	A 475		

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A 475	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain a bed occupancy by Medicaid-eligible residents of at least 10 percent (%) of the total bed complement, in accordance with N.J.S.A. 26:2H-12.16 et seq. Specifically, the facility had a total bed capacity of 130 and eight residents who were eligible for Medicaid (six percent). Findings included: During an interview on 11/03/2025 at 8:30 AM, the Executive Director (ED) stated that the facility's total bed capacity was 130 residents. A list provided by the facility of Medicaid approved residents revealed eight residents were approved for Medicaid. During an interview on 11/04/2025 at 3:23 PM, the ED stated that he was aware that the facility was not meeting the occupancy requirement for Medicaid-eligible residents. He stated that he and the Business Office Manager tracked admissions, and they tried to assist residents who may be eligible for Medicaid. He stated that the residents did not always qualify for Medicaid because they had assets that made them ineligible. During an interview on 11/04/2025 at 4:32 PM, the Resident Services Director (RSD) stated she thought that 15% of the resident bed capacity was required to have Medicaid and was aware that they were not meeting that requirement. She stated that the ED and marketing staff recruited residents who received Medicaid, and they were always working with residents to see if they were eligible; however, most of the facility's residents	A 475		

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A 475	Continued From page 4 had assets that made them Medicaid ineligible.	A 475		
A 935	8:36-11.4(b) Pharmaceutical Services (b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's requirements, cautionary or accessory warnings, and all Federal and State laws and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00188490 Based on observation, interview, record review, and facility policy review, the facility failed to follow medication physician orders for 2 (Resident #1 and Resident #6) of 3 residents. Specifically, the facility failed to administer medications as ordered to treat [redacted] for Resident #1. The facility also failed to ensure Resident #6's [redacted] was not [redacted] prior to administering the medication to the resident. Findings included: 1. A facility policy titled, "Medication Management-Acquisition Ordering or Re-Ordering [facility initials]," dated 08/2024, revealed, "It is the policy of [the facility] to ensure	A 935		

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A 935	Continued From page 5	A 935		

that the medications prescribed for each resident are on-site and available in accordance with the prescribed medication regime in a timely manner." Per the policy, "All medications orders must be filled in a timely manner regardless of who has the responsibility: facility staff, residents, or family/representative." The policy also revealed, "When a new prescription is received by the facility, the prescription should be faxed or electronically sent immediately to the Pharmacy by the licensed nurse on duty; the fax confirmation must be attached to a copy of the prescription and placed in the resident's record."

A facility policy titled, "Medication Management-Documentation," dated 08/2024, revealed, "3. c. The Pharmacy and, in some circumstances, the licensed nurse will carefully transcribe the order into the eMAR, exactly as written on the prescription, along with the entry date."

Resident #1's handwritten prescription dated NJ Exec Order 26.4b1 revealed Medical Doctor (MD) #8 ordered to continue NJ Exec Order 26.4b1) by mouth daily. Per the prescription, Resident #1's NJ Exec Order 26.4b1) three times daily with meals per NJ Exec Order 26.4b1 based on the resident's NJ Exec Order 26.4b1. The order for NJ Exec was increased as follows:
- NJ Exec Order 26.4b1 per NJ Exec Order 26.4b1,
- NJ Exec Order 26.4b1,
- NJ Exec Order 26.4b1,
- NJ Exec Order 26.4b1,
- NJ Exec Order 26.4b1 and

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A 935	Continued From page 6 - NJ Exec Order 26.4b1 . Resident #1's NJ Exec Order 26.4b1 "eMAR [electronic Medication Administration Record] Summary," revealed the facility revised the eMAR with a new start date for NJ Exec Order 26 and revised the eMAR with the order change for NJ Exec Order 26.4b1 However, on NJ Exec Order 26.4b1, per the eMAR, the facility discontinued an order for NJ Exec Order 26.4 that had a start date of NJ Exec Order 26.4b1, and did not add the NJ Exec Order 26.4b1 order for NJ Exec Order 26.4 back to the NJ Exec Order 26.4b eMAR; subsequently, there was no documented evidence the facility administered NJ Exec Order 26.4 per physician's orders from NJ Exec Order 26.4b1 until NJ Exec Order 26.4b1 when the medication was added to Resident #1's NJ Exec Order 26.4b eMAR and staff documented that the medication was administered beginning NJ Exec Order 26.4b1. A handwritten prescription dated NJ Exec Order 26.4b1 revealed MD #8 increased Resident #1's NJ Exec Order 26 NJ Exec Order 26.4b1 once daily at bedtime, continued NJ Exec Order 26.4b1 by mouth daily, and NJ Exec Order 26.4b1 the amount of NJ Exec Order 26.4b1 to be given NJ Exec Order 2 as follows: - NJ Exec Order 26.4b1 , - NJ Exec Order 26.4b1 , - NJ Exec Order 26.4b1 , - NJ Exec Order 26.4b1 , - NJ Exec Order 26.4b1 , - NJ Exec Order 26.4b1 , and - NJ Exec Order 26.4b1 Resident #1's "Progress Notes," dated NJ Exec Order 26.4b1 at 4:04 PM, revealed the Resident Services Director (RSD) documented that Resident #1 went to MD #8's office that day with a list of medications and NJ Exec Order 26.4b1 for the past 30 days. Per the notes, MD #8 changed the resident's NJ Exec Order 26.4b1 at	A 935		

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A 935	Continued From page 7 bedtime. The Progress Notes did not address the prescription change for [redacted]. Resident #1's [redacted] eMAR revealed the facility revised the [redacted] and [redacted] medication based on the [redacted] prescription. However, the eMAR for [redacted] revealed the facility did not transcribe the [redacted] prescription for the [redacted] in [redacted] to the eMAR. Subsequently, per the eMAR, the facility continued to administer [redacted] based on the order from [redacted]. Resident #1's "Progress Notes," revealed an "Incident" note dated [redacted] at 7:59 PM that indicated that the RSD was verifying physician orders and found an order for [redacted] to [redacted] with no order for [redacted] Per the notes, the RSD called MD #8's office to clarify the order, and the physician's nurse stated she would notify the physician. Resident #1's Progress Notes revealed Resident #1's family member reported that that MD #8 had changed Resident #1's [redacted] and brought in the prescription dated [redacted] with the order for the [redacted]. The notes revealed the RSD processed the prescription that the family member gave her and forwarded the prescription to their pharmacy. During an interview on 11/04/2025 at 1:38 PM, the RSD stated that when a physician saw a resident in their office and the resident used an independent pharmacy, the doctor could not send an electronic prescription (e-scribe) to the facility pharmacy. She stated that the doctor had to write the prescription. The RSD stated that family members then brought the prescription to her or a nurse, and they faxed the prescription to the	A 935		

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A 935	Continued From page 8	A 935		

facility pharmacy so the medication could be added to the resident's eMAR. She stated a family member came to the facility to take Resident #1 to an appointment in [NJ Exec Order 26.4b1], asked for a list of the resident's medications, and mentioned there had been a change in the resident's [NJ Exec Order 26.4b1]. Per the RSD, she called the physician's office because she did not recall a change to the resident's [NJ Exec Order 26.4b1] and the physician confirmed that he had given the family member an order to change the resident's [NJ Exec Order 26.4b1] in [NJ Exec Order 26.4b1]. According to the RSD, Resident #1's family member stated they gave the prescription to the Wellness Nurse (on [NJ Exec Order 26.4b1]); however, the RSD stated the facility did not receive the prescription until [NJ Exec Order 26.4b1]

During an interview on 11/04/2025 at 2:48 PM, the Regional Director of Clinical Services (RDCS) stated that after listening to the conversation the surveyor had with the RSD, she investigated to see what happened. She stated that according to Resident #1's eMAR, the NJ Exec Order 26.4b1 order was not received and added to the eMAR until [NJ Exec Order 26.4b1] because the family member never gave the facility the prescription. The RDCS was unable to explain how the resident's [NJ Exec Order 26.4b1] was changed to [NJ Exec Order 26.4b1], and the [NJ Exec Order 26.4b1] order was updated on [NJ Exec Order 26.4b1], based on the same prescription with orders to change the [NJ Exec Order 26.4b1] dosage.

During an interview on 11/04/2025 at 3:20 PM, the Executive Director (ED) stated his expectation was that physician orders for medications be sent to the facility pharmacy so the medication could be delivered and administered as prescribed. He indicated that he was notified that the reason Resident #1's [NJ Exec Order 26.4b1] orders were not implemented was because the family member did

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A 935	Continued From page 9	A 935		

not bring in the prescription. He stated that he was not sure how two of the medications ([redacted] and [redacted] from the prescription were changed on [redacted], and the [redacted] was not addressed.

2. An undated facility policy titled, "Medication Management-Assistance with Medications-[Facility Initials]," indicated general procedures included, "Medications may only be crushed upon: Approval by the Medical Provider."

The package insert information (provided by the facility pharmacy) for "Potassium Chloride Extended-release [ER]Tablets," revised 04/2019, revealed "Information for Patients" indicated, "Physicians should consider reminding the patient of the following." "To take each dose without crushing, chewing, or sucking the tablets. If those patients are having difficulty swallowing whole tablets, they may try one of the following alternate methods of administration: 1. Break the tablet in half, and take each half separately with a glass of water. 2. Prepare and aqueous (water) suspension as follows: 1. Place the whole tablet(s) in approximately ½ glass of water (4 fluid ounces). 2. Allow approximately 2 minutes for the tablet(s) to disintegrate. 3. Stir for about half a minute after the tablet(s) has disintegrated. 4. Swirl the suspension and consume the entire contents of the glass immediately by drinking or by the use of a straw. 5. Add another 1 fluid ounce of water, swirl, and consume immediately. 6. Then, add an additional 1 fluid ounce of water, swirl, and consume immediately."

A "Resident Face Sheet" indicated Resident #6 moved into the facility on [redacted]. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of

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A 935	Continued From page 10 NJ Exec Order 26.4b1 . A written prescription dated NJ Exec Order 26.4b1 revealed Resident #6's physician prescribed NJ Exec Order 26.4b1 by mouth three times daily (TID). Resident #6's NJ Exec Order 26.4b1 medication package revealed the resident received NJ Exec Order 26.4b1 with instructions to take NJ Exec Order 26.4b1 by mouth three times daily. The medication package was also labeled with instructions that the "May be or allowed to NJ Exec Order 26.4b1 before rinse down with water but do not chew." On 11/03/2025 at 3:18 PM, Licensed Practical Nurse (LPN) #6 was observed NJ Exec Order 26.4b1 , mixing the medication in , and administering them to Resident #6. During an interview on 11/03/2025 at 3:24 PM, LPN #6 stated that Resident #6 usually took their NJ Exec Order 26.4b1 because the were and sometimes got in the resident's He stated that because the were the resident was not allowed to them. He stated that ' indicated the were NJ Exec Order 26.4b1, and that meant it took longer for the medication to He stated that if the were cut in that it would not be , and if the were only in the resident would attempt to it. During an interview on 11/04/2025 at 9:38 AM, the Director of Pharmacy (DOP) stated that if a was not meant to be then it should	A 935		

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A 935	Continued From page 11 not be NJ Exec Order 26.4b either. She stated that NJ Exec Order 26.4b1 could be NJ Exec Order 26.4b1 or made into a NJ Exec Orde by allowing the NJ Exec Orde to NJ Exec Order 26.4b1, but the NJ Exec Orde should not be NJ Exec Order 26.4b Per the DOP, the NJ Exec Order 2 were NJ Exec Order 26.4b1, so NJ Exec Order 26.4b1 in NJ Exec O would not disrupt the dispersible nature of the NJ Exec Order 2 The DOP stated that NJ Exec Order 26.4b the table and placing it in NJ Exec Order 26.4b1 could cause the ingredients in the medication to be NJ Exec Order 26.4b all at once. During an interview on 11/04/2025 at 9:55 AM, the Resident Services Director (RSD) stated that NJ Exec NJ Exec O whether they were NJ Exec Order 26.4b1 or NJ Exec Order 26. should not be NJ Exec Order 26.4 She stated that on the blister pack, it was noted that the NJ Exec Orde could be NJ Exec Order 26.4b1 . She stated that based on the label, she would expect that the medication should not be NJ Exec Order 26.4b	A 935		
A1041	8:36-14.3(a) Emergency Services and Procedures (a) The facility shall conduct at least one drill of the emergency plans every month. The 12 drills shall be conducted on a rotating basis, to ensure that four drills occur during each working shift on an annual basis. The facility shall maintain documentation of all drills, including the date, hour, description of the drill, participating staff, and signature of the person in charge. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, other natural disaster, bomb threat, or nuclear accident (a total of 12 drills). All staff shall participate in at least one drill annually, and selected residents may participate in drills.	A1041		

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A1041	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on interview and facility document and policy review, the facility failed to ensure that at least one additional emergency disaster drill, other than fire, was conducted annually and failed to maintain documentation that all staff participated in at least one fire drill annually. Findings included: 1. An undated facility policy titled, "Disaster and Emergency Preparedness," indicated, "Staff participate in regular disaster drills." During an interview on 11/04/2025 at 4:51 PM, the Environmental Services Director (ESD) stated that he knew he had to conduct a disaster drill but had not done one yet. During a follow-up interview on 11/04/2025 at 5:17 PM, the ESD stated he was unable to find evidence that a disaster drill had been completed annually. During an interview on 11/04/2025 at 5:42 PM, the Executive Director (ED) stated the expectation was to have a disaster drill once per year. He stated that the facility maintenance staff person prior to the ESD took all documents with him and the ESD was unable to find documentation for a disaster drill. 2. An undated facility policy titled, "Fire Safety," indicated, "Each Community will conduct tailored fire drills in accordance with state and local	A1041		

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	12A040	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD AT PRINCETON	1 HOSPITAL DRIVE PLAINSBORO, NJ 08536

(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
A1041	Continued From page 13 regulations and in accordance with the Community's customized evacuation form." The policy revealed, "If associates are unable to participate in drills because of absence, the safety committee is responsible for holding additional drills and/or in-services and documenting such associates' participation to achieve the quarterly standard. An undated facility document for "Fire and Safety," revealed, "Employees are required to participate in regular fire drills run by the Environmental Service Director." A facility document titled, "Annual Fire Drill Log of Attendance," indicated that 46 staff members had not attended a fire drill in 2025. During an interview on 11/04/2025 at 5:15 PM, the Business Office Manager (BOM) stated the facility did not have any staff sign-in sheets for fire drills for 11/2024 and 12/2024, prior to the current Environmental Services Director (ESD) taking over. During an interview on 11/04/2025 at 4:53 PM, the BOM stated that the "Annual Fire Drill Log of Attendance" was for drills conducted since 01/2025. She stated that she believed a lot of staff on the "Annual Fire Drill Log of Attendance" who did not have a date next to their name, indicating they had participated in a fire drill, had, in fact, participated in a fire drill. However, she stated that if staff members had not signed the ESD's sheet then she did not have the documentation to prove that they attended a fire drill. Per the BOM, staff supervisors were notified if their staff did not participate in a drill, and the list also went to the department heads.	A1041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12A040	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD AT PRINCETON	1 HOSPITAL DRIVE PLAINSBORO, NJ 08536

(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
A1041	Continued From page 14 During an interview on 11/04/2025 at 5:22 PM, the Resident Services Director (RSD) stated that fire drills were conducted monthly and everyone who was working during the shift was included. The RSD stated that the ESD was responsible for sign-in sheets for those who participated. According to the RSD, the frequency of staff participation in fire drills depended on when they were working, and there was no requirement for the frequency of staff participation in the drills. During an interview on 11/04/2025 at 4:51 PM, the ESD revealed he was aware that everyone was expected to participate in at least one fire drill per year. However, according to the ESD, there was no system to track who had attended a fire drill or who needed to participate in one. During an interview on 11/04/2025 at 5:42 PM, the Executive Director (ED) stated that the expectation was for fire drills to be completed monthly, on rotating shifts, and all staff should participate in at least one drill during the year.	A1041		
A1043	8:36-14.3(b) Emergency Services and Procedures (b) The facility shall request of the local fire department that at least one joint fire drill be conducted annually. Upon scheduling a joint fire drill, the facility shall notify first aid and civil defense agencies of this drill and shall participate in community-wide disaster drills. This REQUIREMENT is not met as evidenced by: Based on facility policy review and interview, the	A1043		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12A040	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD AT PRINCETON	1 HOSPITAL DRIVE PLAINSBORO, NJ 08536

(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
A1043	Continued From page 15 facility failed to request that the local fire department conduct a joint fire drill annually. Findings included: An undated facility policy titled, "Fire Safety," indicated, "Each Community will conduct tailored fire drills in accordance with state and local regulations and in accordance with the Community's customized evacuation form." During an interview on 11/04/2025 at 4:51 PM, the Environmental Services Director (ESD) stated that he thought it was a requirement for the fire department to be invited to participate in a facility fire drill; however, the fire department had not been invited since he started the ESD position approximately seven months prior. He stated that he did not know when the fire department was last invited. During an interview on 11/04/2025 at 5:22 PM, the Resident Services Director (RSD) stated that she did not think it was a requirement to request the fire department for a fire drill. During an interview on 11/04/2025 at 5:42 PM, the Executive Director (ED) stated that there was no expectation for the fire department to participate in a fire drill.	A1043		
A1225	8:36-17.3(b)(8)(i-ii) Resident Environment (b) The following safety conditions shall be met: 8. An electrician licensed in accordance with N.J.A.C. 13:31 shall annually inspect and provide a written statement that the electrical circuits and wiring in the facility are	A1225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12A040	A. BUILDING: _____ B. WING _____	C 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD AT PRINCETON	1 HOSPITAL DRIVE PLAINSBORO, NJ 08536

(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
A1225	Continued From page 16 satisfactory and in safe condition; i. The written statement shall include the date of inspection, and shall indicate that circuits are not overloaded, that all wiring and permanent fixtures are in safe condition, and that all portable electrical appliances, including lamps, are Underwriters Laboratories (U.L.) approved; and ii. The written statement shall be available for review by the Department during survey. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to have the facility inspected by a licensed electrician. This deficient practice was evidenced by the following: On 11/6/25 at 9:50 a.m., the surveyor reviewed the facility's electrical inspections report which revealed that the facility did not have the annual electrical inspections for the years 2023, 2024, and 2025. At 12:30 p.m., the surveyor interviewed the Executive Director (ED) regarding the above annual electrical inspections. The ED stated that he recently took over the position and will ensure that the facility become current with the annual inspections.	A1225		

POC #3 received 1/29/26
Accepted 1/30/26

MAPLEWOOD
AT PRINCETON

January 29, 2026

Plan of Correction #3
Maplewood at Princeton
License No.: 12A040
Date Survey Completed: November 4, 2025

Tag NJ A361 – Resident Rights

1. **Corrective action taken for residents found to have been affected by the deficient practice**

   Immediately upon identification of the deficient practice, all Home Health Aides ("HHAs") and direct care staff were re-educated by the Director of Nursing ("DON") on November 5, 2025 on the requirement to **knock, announce themselves, and request permission prior to entering a resident's apartment**. Education was provided to involved staff on resident dignity, privacy, and autonomy in accordance with Resident Rights Policy.

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

   Every resident has the potential to be affected by the deficient practice with respect to resident rights.

   The facility conducted a review of all residents receiving HHA or direct care services to determine if any additional residents may have been affected by the deficient practice.

   DON performed rounds during care visits to ensure staff compliance with knocking and permission-to-enter procedures. Any concerns identified during these observations were addressed immediately through re-education.

3. **Measures put into place and systemic changes made to ensure the deficient practice will not recur**

On November 5, 2025, the facility developed and implemented a **formal written policy and procedure** entitled *"Resident Right to Privacy and Permission to Enter Resident Apartments."* This policy clearly outlines the requirement for staff to knock, announce themselves, identify their role, and obtain resident permission prior to entering any resident apartment.

Education on *Resident Right to Privacy and Permission to Enter Resident Apartments* has been incorporated (as of December, 2025) into orientation for all newly hired staff.

4. **How the facility will monitor corrective actions to ensure continued compliance and prevent recurrence**

To monitor ongoing compliance, the facility implemented a **Resident Rights Policy and Procedure**. DON and/or Assistant Director of Nursing ("ADON") will conduct **random observational audits** of staff entering resident apartments **weekly for the first 4 weeks**, then **monthly thereafter for 3 months**. Audit results will be documented and reviewed by the Executive Director ("ED")/designee.

Any identified noncompliance will result in immediate re-education. Monitoring results will be reviewed during **Quality Assurance/Performance Improvement ("QAPI")** quarterly meetings to evaluate trends and ensure sustained compliance with "Resident Rights."

Date of Compliance

The facility achieved compliance with the requirements set forth in Tag A361 regarding Resident Rights on December 1, 2025, and will maintain ongoing monitoring to ensure continued compliance.

approved 1/30/26

Tag A475 – Medicaid Occupancy Requirement

1. **Corrective action taken for residents found to have been affected by the deficient practice**

   While the facility is not in compliance with the Medicaid occupancy requirement, no resident has been affected by this deficiency.

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

   Any resident who is qualified for Medicaid has the potential to be affected by the deficient practice with respect to the required Medicaid occupancy level. The facility has already conducted a comprehensive review of all current residents to identify those who are Medicaid-eligible, have pending Medicaid applications, or may potentially qualify for Medicaid. As of January 26, 2026, there were eight (8) residents at Maplewood at Princeton who are Medicaid beneficiaries and seven (7) residents who have **Medicaid applications pending.**

The status of residents' Medicaid applications is checked monthly, through the ED's (or designee's) review of information in the **Medicaid Census Tracking System.**

3. **Measures put in place and systemic changes made to ensure the deficient practice will not recur**

   Effective December 1, 2025, the facility implemented systemic changes for achieving compliance with the Medicaid occupancy requirement, including:

- Use of the **Medicaid Census Tracking System,** which was established in July, 2023, and is monitored by the ED/designee. Since July, 2023, the Medicaid Census Tracking System spreadsheet has been continually updated as new information becomes available. While the information in the Tracking System spreadsheet is continually updated, the manner in which the System is used has not changed.

- Beginning in December, 2025, enhanced coordination by the ED/designee with Medicaid application representatives to track application status, clinical approvals, and expirations. Each of the residents with a Medicaid application pending is represented either by Senior Planning Services or by one of two law firms. The ED last checked in with one of the involved law firms on December 17, 2025, with the other law firm on January 23, 2026, and with Senior Planning Services on January 26, 2026.

4. **How the facility will monitor corrective actions to ensure continued compliance and prevent recurrence**

In July, 2023, the ED implemented the use of a **Medicaid Census Tracking System** to document application status, clinical approvals, denials, expirations, and move-outs. The information in the System/spreadsheet is continually updated and monitored by the ED/designee.

All of the interventions with respect to this deficient practice were implemented on or before January 26, 2026.

Monitoring will continue on an ongoing basis to ensure sustained compliance with the Medicaid occupancy requirement.

Date of Compliance

The facility anticipates achieving compliance with the Medicaid occupancy requirement by the end of 2026.

approved
1/30/26

Tag A935 – Pharmaceutical Services

1. Corrective action taken for residents found to have been affected by the deficient practice

Immediately upon identification of the deficient practices, corrective actions were taken for the affected residents.

- **Resident #1:** The resident's [redacted] medication orders were reviewed, clarified, and reconciled on [redacted] with the physician. Nursing staff ensured on [redacted] that medications were administered exactly as ordered to treat the resident's [redacted] The resident was monitored on [redacted] for any [redacted] and [redacted] outcomes were identified.
- **Resident #6:** The physician order for [redacted] was reviewed by the DON on [redacted] The resident's physician was notified that the medication had been [redacted] Nursing staff were re-educated by the DON (November 14, 2025 – November 23, 2025) that [redacted] medications are [redacted] The resident's medication administration was corrected [redacted] to ensure compliance with the physician's order and manufacturer guidelines.

Both residents' medication records were reviewed for accuracy on November 4, 2025 by the DON and physician orders were confirmed to ensure proper administration moving forward.

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

Every resident has the potential to be affected by the deficient practice with respect to administration of medications. On November 5, 2025, the DON conducted a review of all current residents' medication administration records ("MARs") to identify any additional residents who receive medications that are time-sensitive, high-risk, or extended-release formulations. Particular attention was given to medications requiring specific administration techniques, including diabetes medications and extended-release medications.

On November 10, 2025, DON reviewed physician orders and MARs to ensure consistency and compliance. Any discrepancies identified were addressed immediately through correction of the MAR and staff re-education.

3. **Measures put into place and systemic changes made to ensure the deficient practice will not recur**

To prevent recurrence, the facility implemented the following systemic changes:

- All nursing staff were **re-educated on medication administration** November 14, 2025 – November 23, 2025 by the DON, with emphasis on:
  - The **Five Rights of Medication Administration**,
  - Proper administration of extended-release medications and medications that are not to be crushed, and
  - Following physician orders exactly as written.
- Education was documented and incorporated into ongoing competency requirements.
- The **Five Rights of Medication Administration** were posted on November 23, 2025 prominently in **each medication room** for easy reference by all staff.
- Medication administration policies were reviewed by the DON and reinforced by the DON during in-servicing conducted November 14 – November 23, 2025 to ensure alignment with current standards of practice and manufacturer guidelines.

4. **How the facility will monitor corrective actions to ensure continued compliance and prevent recurrence**

The facility implemented a **Medication Administration Monitoring In-service** on November 14, 2025 under the direction of the DON and/or ADON that includes:

- **Random observational audits by DON and/or ADON of 100% of nursing staff** conducting medication administration **monthly for three (3) months**, and
- Frequent audits that will focus on adherence to physician orders, proper medication preparation, and compliance with the Five Rights.

Any noncompliance identified will result in immediate re-education. Monitoring results will be reviewed as part of the facility's QAPI program to ensure sustained effectiveness of corrective measures.

Date of Compliance

The facility achieved compliance with the requirements set forth in Tag A935 on **November 23, 2025** and will maintain ongoing monitoring to ensure continued compliance.

approved 1/30/26

Tag A1041 – Emergency Preparedness / Fire and Disaster Drills

1. **Corrective action taken for residents found to have been affected by the deficient practice**

   No resident was affected by the deficient practice.

   While no resident harm occurred, the facility recognizes the importance of ensuring staff readiness to respond appropriately during emergencies. Upon identification of the deficiency, the facility took corrective action to address emergency preparedness and staff participation in required drills. A fire/disaster drill was conducted on December 29, 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 by a deficient practice with respect to emergency preparedness. On December 29, 2025, the Environmental Services Director ("ESD") reviewed emergency preparedness documentation, including fire drill logs and disaster drill records, to identify gaps in staff participation and documentation.

3. **Measures put into place and systemic changes made to ensure the deficient practice will not recur**

   The facility implemented the following systemic changes:

   - On December 23, 2025, the ED developed and implemented an **Emergency Drill Attendance Tracking Form.**
   - The **Human Resources Director** will monitor the **Emergency Drill Attendance. Tracking Form monthly** to ensure that all staff participate in at least one fire drill annually.

   Staff who fail to attend scheduled drills will be rescheduled to corrective action per facility policy if noncompliance continues.

4. **How the facility will monitor corrective actions to ensure continued compliance and prevent recurrence**

The facility has incorporated emergency drill compliance into its **Quality Assurance/Performance Improvement Meeting,** which includes:

- Monthly review of fire and disaster drill attendance logs by the Human Resources Director for a period of three (3) months,
- Quarterly review by the ED to verify sustained compliance for a period of six (6) months, and
- Immediate corrective action if attendance or drill frequency falls below regulatory requirements.

Monitoring will be ongoing to ensure all staff participate in required drills and that emergency preparedness standards are maintained.

Date of Compliance

The facility will achieve compliance with the fire and disaster drill requirements set forth in Tag A1041 by **March 1, 2026,** by which date it is expected that each staff member (7 days, 3 shifts) will have participated in a drill, with corrective systems in place to prevent recurrence.

approved 1/30/26

Tag A1043 – Joint Fire Drill with Local Fire Department

1. **Corrective action taken for residents found to have been affected by the deficient practice**

   No resident was affected by the deficient practice. Upon identification of the deficiency, the facility contacted the local fire department and submitted a formal request for a joint fire drill. A joint fire drill was conducted on **January 7, 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 by a deficient practice with respect to emergency preparedness. Ongoing identification of potential risk will be achieved through routine review of emergency preparedness records to ensure that required joint fire drill requests are submitted and maintained annually. The ESD will be responsible for reviewing emergency preparedness records to ensure compliance and for scheduling drills with the local fire department.

3. **Measures put into place and systemic changes made to ensure the deficient practice will not recur**

   To prevent recurrence, the facility, on November 10, 2025, implemented the following systemic changes:

   - The **ESD** is responsible for ensuring that a joint fire drill request is submitted to the local fire department annually.
   - The **ED will review joint fire drill request status with the ESD every six (6) months.**
   - Emergency preparedness policies were updated on November 15, 2025 to include specific timelines and responsible parties for joint fire drill requests and documentation.
   - Documentation of requests, confirmations, and drill completion will be maintained in the facility's emergency preparedness records in TELS ("TELS" is a system that Maplewood's ESD uses to track and manage scheduled maintenance operations).

4. **How the facility will monitor corrective actions to ensure continued compliance and prevent recurrence**

The facility has incorporated joint fire drill compliance into its **Quality Assurance/Performance Improvement Meeting** quarterly, which includes:

- Semi-annual reviews of joint fire drill request documentation by the ESD and ED,
- Verification that requests are current, submitted timely, and properly documented,
- Review of compliance during QAPI quarterly meetings, and
- Immediate corrective action if a lapse in documentation or scheduling is identified.

Monitoring will continue on an ongoing basis to ensure sustained compliance with joint fire drill requirements.

Date of Compliance

The facility achieved compliance with the joint fire drill requirements set forth in Tag A1043 on **January 7, 2026**, the date the joint fire drill was conducted.

approved 1/30/26

Tag A1225 – Electrical Safety Inspection

1. **Corrective action taken for residents found to have been affected by the deficient practice**

   No resident was affected by the deficient practice with respect to electrical safety. Upon identification of the deficiency, the facility took immediate corrective action to ensure resident safety. The facility arranged for an **Annual Electrical Safety Inspection by a licensed electrician**, which was **completed on December 4, 2025**. No electrical hazards were identified that posed immediate risk to residents, and no resident harm occurred.

   Documentation of the completed inspection was obtained and maintained by the facility.

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 by a deficient practice with respect to electrical safety.

   Ongoing identification of potential risk will occur through scheduled reviews by the ESD of all required safety inspections and documentation to ensure continued compliance.

3. **Measures put into place and systemic changes made to ensure the deficient practice will not recur**

   To prevent recurrence, the facility, on November 10, 2025, implemented the following systemic changes:

   - All required life safety and environmental inspection forms, including electrical safety inspections, will be **uploaded and maintained in the TELS system.**
   - The **ED/designee** is responsible for ensuring timely completion and documentation of annual electrical inspections.
   - A tracking schedule was established to alert leadership in advance of inspection due dates.
   - Facility policies were reinforced to require documentation retention and electronic upload of all regulatory inspection records.

4. **How the facility will monitor corrective actions to ensure continued compliance and prevent recurrence**

The facility has incorporated electrical safety compliance into its **Quality Assurance/Performance Improvement Program**, including:

- **Quarterly reviews** of TELs uploads to ensure all required inspection documentation is current and complete,
- Verification by the ED/designee that annual electrical inspections are completed timely, and
- Immediate corrective action if documentation is missing or inspections are approaching expiration.

Monitoring will be ongoing to ensure sustained compliance with electrical safety requirements.

Date of Compliance

The facility achieved compliance with the electrical inspection and documentation requirements set forth in Tag A1225 on **December 4, 2025**, the date the Annual Electrical Safety Inspection was completed.

approved 1/30/26

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
12A040	A. Building B. Wing	1/30/2026

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD AT PRINCETON	1 HOSPITAL DRIVE PLAINSBORO, NJ 08536

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 A0935 Reg. # 8:36-11.4(b) LSC	Correction Completed 11/23/2025	ID Prefix A1041 Reg. # 8:36-14.3(a) LSC	Correction Completed 03/01/2026	ID Prefix A1043 Reg. # 8:36-14.3(b) LSC	Correction Completed 01/07/2026
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
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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 11/4/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

EVENT ID: 6QV112

STATE FORM: REVISIT REPORT (11/06)

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
12A040		1/30/2026

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD AT PRINCETON	1 HOSPITAL DRIVE PLAINSBORO, NJ 08536

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A1225 Reg. # 8:36-17.3(b)(8)(i-ii) LSC	Correction Completed 12/04/2025	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
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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	
11/4/2025	☐ 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
12A040 Y1	A. Building B. Wing Y2	1/30/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD AT PRINCETON	1 HOSPITAL DRIVE PLAINSBORO, NJ 08536

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0361	Correction	ID Prefix A0475	Correction	ID Prefix A0935	Correction
Reg. # 8:36-4.1(a)(4)	Completed	Reg. # 8:36-5.1(h)	Completed	Reg. # 8:36-11.4(b)	Completed
LSC	12/01/2025	LSC	01/26/2026	LSC	11/23/2025
ID Prefix A1041	Correction	ID Prefix A1043	Correction	ID Prefix	Correction
Reg. # 8:36-14.3(a)	Completed	Reg. # 8:36-14.3(b)	Completed	Reg. #	Completed
LSC	03/01/2026	LSC	01/07/2026	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	
11/4/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO