

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11A013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/06/2026
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NAME OF PROVIDER OR SUPPLIER ARTIS SENIOR LIVING OF PRINCETON JUNCT	STREET ADDRESS, CITY, STATE, ZIP CODE 861 ALEXANDER ROAD PRINCETON, NJ 08540
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>Complaint #: NJ 00189561 and NJ 00189580</p> <p>Date of Survey: 1/5/2026 and 1/6/2026</p> <p>CENSUS: 62</p> <p>SAMPLE SIZE: 3</p> <p>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.</p> <p>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.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administrator's Responsibilities</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/14/26

New Jersey Department of Health

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to follow its policy titled, "SUICIDE AND SUICIDAL IDEATION RECOGNITION AND GUIDELINES" for 1 of 3 residents reviewed, Resident #1. This deficient practice was evidenced by the following:</p> <p>On 1/5/26 at 10:45 a.m., the surveyor reviewed Resident #1's medical record (MR), which revealed that Resident #1 was admitted to the facility on [redacted] with diagnoses of [redacted] with NJ Exec Order 26.4b1.</p> <p>At 11:08 a.m., the surveyor reviewed Resident #1's progress notes (PN) in the medical record (MR), dated [redacted] at 11:17 p.m., written by a Licensed Practical Nurse (LPN) #3, which documented, "Resident was stating that [redacted] wants to [redacted] by [redacted] and wants to [redacted]."</p> <p>The MR did not reveal documented evidence that Resident #1 was evaluated, in-house, by a physician or was sent to the hospital for evaluation following the resident's [redacted] of [redacted] on [redacted]. On [redacted] Resident #1 [redacted] to [redacted] by [redacted] as he/she reported to staff by [redacted].</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>At 1:35 p.m., the surveyor interviewed the Director of Health and Wellness (DHW) and inquired about Resident #1's ^{NJ Exec Order 26.4b1} of ^{NJ Exec Order 26.4b1} on ^{NJ Exec Order}. The DHW stated and confirmed that the resident was not sent to the hospital for evaluation.</p> <p>The surveyor reviewed the facility policy dated 1/23 and titled, "SUICIDE AND SUICIDAL IDEATION RECOGNITION AND GUIDELINES", which revealed under FUNDAMENTAL INFORMATION, "Any resident with suicidal ideations must be taken seriously and must undergo a mental health evaluation (either in-house or at another facility/office). Such resident cannot remain in the community... until the resident is evaluated by a medical health professional and has documentation stating that he/she is not a danger to him/herself".</p>	A 310		
A 401	<p>8:36-4.1(a)(22) Resident Rights</p> <p>(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:</p> <p>22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care;</p>	A 401		

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A 401	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189580</p> <p>Based on interview and record review, it was determined that the facility failed to ensure a safe environment while providing care and services to residents for 1 of 3 residents reviewed for safety, Resident #1. This deficient practice is evidenced by the following:</p> <p>The Department of Health (DOH) received a Facility Reportable Event (FRE) on [redacted] (a document used by facilities to report events to the DOH). According to the FRE, on [redacted] Resident #1 [redacted] the facility by [redacted] a [redacted] in the [redacted] NJ Exec Order 26.4b1 and used the [redacted] to [redacted] the [redacted]</p> <p>On 1/5/26 at 10:45 a.m., the surveyor reviewed Resident #1's medical record (MR), which revealed that Resident #1 was admitted to the facility on [redacted], with diagnoses of [redacted] with [redacted] NJ Exec Order 26.4b1 .</p> <p>The surveyor reviewed A Progress Notes (PN) which revealed the following documentation:</p> <ol style="list-style-type: none"> 1. The PN, written by a Licensed Practical Nurse (LPN) #1, dated [redacted] at 4:44 p.m., which revealed that Resident #1 was [redacted] and [redacted] NJ Exec Order 26.4b1 ." 2. A PN, written by LPN #2 dated [redacted] at 1:32 p.m., which documented, "Resident [redacted] to [redacted] and voiced that [redacted] will be [redacted] this [redacted] NJ Exec Order 26.4b1 ." 3. A PN, written by LPN #1 dated [redacted] at 	A 401		
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A 401	<p>Continued From page 4</p> <p>11:33 p.m., which documented, "Resident NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 that he/she will be NJ Exec Order 26.4b1."</p> <p>4. A PN, written by LPN #1 dated NJ Exec Order 26.4b1 at 4:28 p.m., which documented, "Resident was NJ Exec Order 26.4b1 around the facility NJ Exec Order 26.4b1 ... Resident was NJ Exec Order 26.4b1 into the lobbies and NJ Exec Order 26.4b1 back to the community in the afternoon around 12pm - 1:30 pm... At 3:41 pm front desk called and said that a resident that matched [Resident #1's] description was NJ Exec Order 26.4b1 ..."</p> <p>5. A PN, written by the Director of Health and Wellness (DHW) dated NJ Exec Order 26.4b1 at 9:16 p.m., which documented, "RN reached out to NJ Exec Order 26.4b1 NP to inform her about seeing resident regarding last incident."</p> <p>6. A PN, dated 1/3/26 at 11:19 p.m., written by (LPN) #3, which documented, "[Resident #1] was stating that [he/she] wants to NJ Exec Order 26.4b1 by NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 The resident was consistently NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. [and] That [he/she's] going to NJ Exec Order 26.4b1 against the NJ Exec Order 26.4b1 to make it look NJ Exec Order 26.4b1."</p> <p>7. A PN, written by LPN #4 dated NJ Exec Order 26.4b1 at 4:05 p.m., documented, "Writer called to neighborhood by care partner. When writer approached dining room NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. When writer asked resident to see the NJ Exec Order 26.4b1 being NJ Exec Order 26.4b1 writer observed NJ Exec Order 26.4b1 When NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 to resident NJ Exec Order 26.4b1 with evaluation and vitals."</p>	A 401		

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A 401	<p>Continued From page 5</p> <p>At 12:45 p.m., the surveyor interviewed LPN #1 and inquired about Resident #1's [redacted]. LPN #1 stated that he admitted Resident #1 to the facility on [redacted] and that Resident #1 informed him that he/she did not [redacted]. LPN #1 stated that he told the other staff that Resident #1 would [redacted]. LPN #1 confirmed that Resident #1 made [redacted] the facility despite the frequent [redacted]. The documentation revealed that [redacted] were the only interventions in place to ensure the [redacted] for Resident #1 following Resident #1's following Resident #1's attempts of [redacted] on [redacted] and [redacted].</p> <p>At 1:35 p.m., the surveyor interviewed the DHW and inquired about Resident #1's [redacted]. The DHW stated that she was made aware of Resident #1's [redacted] on [redacted] and that she made a referral for [redacted] evaluation. The DHW added that the resident was also placed on [redacted] and no other interventions were in place at the time of the resident's [redacted].</p> <p>The surveyor reviewed the facility policy and procedure dated 1/23 and titled, "SUICIDE AND SUICIDAL IDEATION RECOGNITION AND GUIDELINES" which revealed under PROCEDURE, "Verbalized suicidal ideations must immediately be reported to the Director of Wellness/Assistant Director if Health and Wellness ... A residents who makes such a statement must not be left unattended (provide one-to-one supervision)until he/she is either transported to an acute care hospital..."</p>	A 401		

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A 475	Continued From page 6	A 475		
A 475	<p>8:36-5.1(h) Types of Services Provided to Residents</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to reach and maintain a level of occupancy by Medicaid-eligible persons of at least ten percent (10%) of its total bed amount. This deficient practice was evidenced by the following:</p> <p>On 1/5/26 at 9:10 a.m., the surveyor observed that the facility's posted license capacity on the wall in the lobby was 64.</p> <p>At 9:18 a.m., during the entrance conference with the Executive Director (ED), the ED confirmed that the facility's capacity was 64 and the current census was 62 with 2 open beds. The surveyor then requested the number of Medicaid recipients currently at the facility. The ED stated that there were only two (2) Medicaid residents.</p>	A 475		

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A 475	<p>Continued From page 7</p> <p>The surveyor inquired if the ED had a waiver for not maintaining 10% of Medicaid eligible residents. The ED stated that the facility did not have a waiver and explained that all rooms were the same size and available for Medicaid residents.</p> <p>At 9:38 a.m., the ED provided the surveyor with a document titled, "Resident Roster Report," which listed all residents in the facility on 1/5/25. The ED identified the two Medicaid residents and one (1) resident with a pending Medicaid application. The document indicated that the facility had two residents on Medicaid and one resident pending Medicaid.</p>	A 475		
A 537	<p>8:36-5.7(a)(1) Policy and Procedure Manual</p> <p>(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:</p> <p>1. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and resident care services of the facility or program;</p>	A 537		

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A 537	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ 00189561</p> <p>Based on observation, interview and record review, it was determined that the facility failed to review its policies and procedures in accordance with N.J.A.C. 8:36-5.7, which required that all policies be reviewed at least annually and that such review be documented. This deficient practice was evidenced by the following:</p> <p>On 1/5/26, during the entrance conference, the surveyor requested the facility's policy and procedure (PP) manual from the Executive Director (ED) for review. The ED informed the surveyor that all PP were electronic. The surveyor reviewed the following policies:</p> <ol style="list-style-type: none"> 1. A facility policy titled, "SUICIDE AND SUICIDE IDEATION RECOGNITION AND GUIDELINES," dated 1/2023. The policy contained no written evidence that indicated that the policy was reviewed or updated annually. 2. A facility policy titled, "HEALTH AND WELLNESS OVERSIGHT," dated 1/23. There was no documentation showing that this policy was reviewed or updated annually. 3. A facility policy titled, "INCIDENT/ACCIDENT REPORTING," dated 1/22. There was no documentation showing that this policy was reviewed or updated annually. <p>On 1/6/26 at 12:26 p.m. the surveyor interviewed the ED and inquired about the policy review dates of the policies provided on 1/5/26. The ED stated</p>	A 537		

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A 537	Continued From page 9 that all policies are updated and reviewed by the corporate office. The ED explained that some policies provided may not have been reviewed annually. The policies reviewed did not include review dates, revision dates, administrative approval, or other documentation demonstrating that the policies were maintained and updated as required under N.J.A.C. 8:36-5.7.	A 537		
A 563	8:36-5.10(a)(2) Reportable Events (a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 or (609) 392-2020 if after business hours, followed within 72 hours by written confirmation, of the following: 2. Any elopements; and This REQUIREMENT is not met as evidenced by: Complaint # NJ 00189580 Based on interview and review of records, it was	A 563		

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A 563	<p>Continued From page 10</p> <p>determined that the facility failed to notify the Department of Health (DOH) of a NJ Exec Order 26.4b1 by a resident immediately by telephone for 1 of 3 residents, Resident #1. This deficient practice was evidenced by the following:</p> <p>On 1/5/26 at 10:45 a.m., the surveyor reviewed Resident #1's medical record (MR), which revealed that Resident #1 was admitted to the facility on NJ Exec Order 26.4b1, with diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.</p> <p>The surveyor reviewed a Progress Note (PN), written by Licensed Practical Nurse (LPN) #3 dated NJ Exec Order 26.4b1 at 11:17 p.m., which documented that, "[Resident #1] was stating that NJ Exec Order 26.4b1</p> <p>NJ Exec Order 26.4b1 The resident was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. [and] That NJ Exec Order 26.4b1 going to NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1."</p> <p>Further review of the PN written by LPN #4 dated NJ Exec Order 26.4b1 at 4:05 p.m., revealed, "Writer called to neighborhood by care partner. When writer approached dining room resident observed on a NJ Exec Order 26.4b1 area. When writer asked resident to see the NJ Exec Order 26.4b1 being NJ Exec Order 26.4b1 writer NJ Exec Order 26.4b1</p> <p>When NJ Exec Order 26.4b1 an NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 to resident NJ Exec Order 26.4b1 with evaluation and vitals."</p> <p>At 1:35 p.m., the surveyor interviewed the Executive Director (ED) and inquired about DOH notification of Resident #1's NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. The ED stated that he did not notify the DOH of Resident #1's NJ Exec Order 26.4b1 because it was not on the list of reportable events to the</p>	A 563		
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A 563	Continued From page 11 DOH; therefore, he was not required to notify the DOH. The surveyor reviewed the facility policy dated 1/23 and titled, "INCIDENT/ACCIDENT REPORTING", which revealed under PROCEDURE, "... 16... Report to your state agency as required."	A 563		
A 745	8:36-7.2(f) Health Care Assmnt. and Health Service Plan (f) The initial health care assessment shall be documented by the registered nurse and shall be updated as required, in accordance with the rules of this chapter and professional standards of practice. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189580 Based on interview and record review, it was determined that the facility failed to ensure a comprehensive assessment was completed by a Registered Nurse (RN) upon a resident's admission to the facility for 1 of 3 residents, Resident #1. This deficient practice was evidenced by the following: On 1/5/26 at 10:45 a.m., the surveyor reviewed Resident #1's medical record (MR), which revealed that Resident #1 was admitted to the facility on [redacted], with diagnoses of [redacted] and [redacted].	A 745		

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A 745	<p>Continued From page 12</p> <p>The surveyor reviewed a Progress Note (PN) written by the Licensed Practical Nurse (LPN) #1 dated ^{NJ Exec Order 26.4b1} at 4:44 p.m., which revealed, "Resident arrived at the facility at 2:05 pm ..."</p> <p>At 12:45 p.m., the surveyor interviewed LPN #1 and inquired about Resident #1's admission. LPN #1 stated that he admitted Resident #1 to the facility and completed the admission assessment.</p> <p>At 1:35 p.m., the surveyor interviewed the Director of Health and Wellness (DHW) and inquired about Resident #1's admission assessment. The DHW stated that an assessment was completed by the Regional Registered Nurse (RN) prior to Resident #1's admission to the facility on ^{NJ Exec Order 26.4b1}. The DHW stated that she completed the RN assessment upon her return to work ^{NJ Exec Order 26.4b1} on ^{NJ Exec Order 26.4b1} and that the Regional RN was the RN for the facility. Additionally, the DHW confirmed that her assessment was the first RN assessment completed for Resident #1 following admission to the facility.</p>	A 745		
A 779	<p>8:36-7.5(c) Provision of Health Care Services</p> <p>(c) The registered professional nurse shall be called at the onset of illness, injury or change in condition of any resident to arrange for assessment of the resident's nursing care needs or medical needs and for needed nursing care intervention or medical care.</p>	A 779		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11A013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/06/2026
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NAME OF PROVIDER OR SUPPLIER ARTIS SENIOR LIVING OF PRINCETON JUNCT	STREET ADDRESS, CITY, STATE, ZIP CODE 861 ALEXANDER ROAD PRINCETON, NJ 08540
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 779	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189580</p> <p>Based on interview and record review it was determined that the facility failed to notify a Registered Nurse (RN) of a NJ Exec Order 26.4b1 when resident NJ Exec Order 26.4b1) for 1 of 3 residents, Resident #1. This deficient practice was evidenced by the following:</p> <p>On 1/5/26 at 10:45 a.m., the surveyor reviewed Resident #1's medical record (MR), which revealed that Resident #1 was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1.</p> <p>Further review of the Progress Note (PN) written by Licensed Practical Nurse (LPN) #3 dated NJ Exec Order 26.4b1 at 11:17 p.m., which revealed, "[Resident #1] was stating that NJ Exec Order 26.4b1 by NJ Exec Order 26.4b1. The resident was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. & That NJ Exec Order 26.4b1 going to NJ Exec Order 26.4b1 to make it look NJ Exec Order 26.4b1."</p> <p>Further review of the PN written by LPN #4 dated NJ Exec Order 26.4b1 at 4:05 p.m., which revealed, "Writer called to neighborhood by care partner. When writer approached dining room resident observed on a NJ Exec Order 26.4b1. When writer asked resident to see the NJ Exec Order 26.4b1, writer observed NJ Exec Order 26.4b1. When NJ Exec Order 26.4b1</p>	A 779		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11A013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/06/2026
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A 779	<p>Continued From page 14</p> <p>NJ Exec Order 26.4b1 to resident NJ Exec Order 26.4b1 with evaluation and vitals."</p> <p>At 1:35 p.m., the surveyor interviewed the Director of Health and Wellness (DHW) and inquired about Resident #1's NJ Exec Order 26.4b1 of NJ E. The DHW explained that she became aware of LPN #3's documentation on NJ Exec Order 26.4b1 when she reviewed Resident #1's chart. The DHW stated that she was not notified of Resident #1's NJ Exec Order 26.4b1 by LPN #3 on NJ Exec Order 26.4b1. The DHW confirmed that LPN #3 should have notified her of NJ E and sent Resident #1 to the hospital for evaluation.</p> <p>At 2:28 p.m., the surveyor attempted to call LPN #3 for a phone interview. A voicemail message was left for LPN #3 by the surveyor.</p> <p>The facility failed to immediately report Resident #1's NJ Exec Order 26.4b1 to the facility's RN when the resident NJ Exec Order 26.4b1 to LPN #3 that he/she NJ Exec Order 26.4b1.</p> <p>The surveyor reviewed the facility policy dated 1/23 and titled, "SUICIDE AND SUICIDAL IDEATION RECOGNITION AND GUIDELINES", which revealed under PROCEDURE: "Verbalized suicidal ideations must be immediately reported to the Director of Health and wellness..."</p>	A 779		
A 781	<p>8:36-7.5(d) Provision of Health Care Services</p> <p>(d) The resident's physician or the physician's designee, that is, another physician or an advanced practice nurse or physician assistant, shall be notified by the licensed professional nurse of any significant changes in the resident's physical or cognitive/mental condition and any</p>	A 781		

New Jersey Department of Health

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A 781	<p>Continued From page 15</p> <p>intervention by the physician shall be recorded.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189580</p> <p>Based on interview and record review, it was determined that the facility failed to notify the physician of a resident's NJ Exec Order 26.4b1 for 1 of 3 residents, Resident #1. This deficient practice was evidenced by the following:</p> <p>Further review the Progress Note (PN) written by Licensed Practical Nurse (LPN) #3 dated NJ Exec Order 26.4b1 at 11:17 p.m., which revealed, "[Resident #1] was stating that NJ Exec Order 26.4b1 _____ The resident was NJ Exec Order 26.4b1 _____ and NJ Exec Order 26.4b1 _____ & That NJ Exec Order 26.4b1 _____."</p> <p>Further review of the PN written by LPN #4 dated NJ Exec Order 26.4b1 at 4:05 p.m., revealed, "Writer called to neighborhood by care partner. When writer approached dining room resident observed on a NJ Exec Order 26.4b1 _____ When writer asked resident to see the NJ Exec Order 26.4b1 _____ When NJ Exec Order 26.4b1 _____ an NJ Exec Order 26.4b1 _____ with evaluation and vitals."</p> <p>The surveyor also reviewed a NJ Exec Order 26.4b1 _____</p>	A 781		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11A013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/06/2026
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A 781	<p>Continued From page 16</p> <p>Evaluation progress note dated [redacted]. Under the "Assessment/Plan:" section, the [redacted] documented, 5. "Continue to [redacted] and [redacted] Notify [redacted] if symptom [redacted] please reconsult our service sooner if it is clinically indicated."</p> <p>The MR did not reveal documented evidence that facility staff notified Resident #1's physician or [redacted] of Resident #1's [redacted].</p> <p>At 1:35 p.m., the surveyor interviewed the Director of Health and Wellness (DHW) and inquired about Resident #1's [redacted] of [redacted] and the [redacted] recommendation on [redacted]. The DHW stated that she was not notified of Resident #1's [redacted] verbalization on [redacted] when she reviewed the resident's record due to the resident's [redacted].</p> <p>The DHW confirmed that Resident #1's [redacted] was not reconsulted and Resident #1's physician was not notified of the resident's [redacted].</p> <p>The surveyor reviewed the facility policy dated 1/23 and titled, "INCIDENT/ACCIDENT REPORTING", which revealed under PROCEDURE, "... 7... The DHW/ADHW or designee will notify the resident's primary care physician of the accident/incident..."</p>	A 781		
A 785	<p>8:36-7.5(f) Provision of Health Care Services</p> <p>(f) If it is determined that there is a medical need for a transfer of a resident to another health care facility because the assisted living</p>	A 785		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11A013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/06/2026
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A 785	<p>Continued From page 17</p> <p>residence, comprehensive personal care home or assisted living program cannot meet the resident's needs, such transfers shall be initiated promptly, in accordance with N.J.A.C. 8:36-5.1(d). The registered professional nurse shall be notified to ensure that the resident is receiving appropriate care during the transfer period.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189561</p> <p>Based on interview and record review, it was determined that the facility failed to transfer resident to the hospital for evaluation for 1 of 3 residents, Resident #1. This deficient practice was evidenced by the following:</p> <p>On 1/5/26 at 10:45 a.m., the surveyor reviewed Resident #1's medical record (MR), which revealed that Resident #1 was admitted to the facility on [redacted] with diagnoses of [redacted] and [redacted].</p> <p>Further review of the Progress Note (PN) written by Licensed Practical Nurse (LPN) #3 dated [redacted] at 11:17 p.m., which documented, "[Resident #1] was stating that [redacted]. The resident was [redacted] & That [redacted].</p> <p>Resident #1's PN did not reveal documented evidence that Resident #1 was sent to the</p>	A 785		

New Jersey Department of Health

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A 785	<p>Continued From page 18</p> <p>hospital for evaluation on [redacted] following the resident's [redacted] NJ Exec Order 26.4b1.</p> <p>Further review of the PN written by LPN #2 dated [redacted] NJ Exec Order at 4:05 p.m., which documented that Resident #1 was observed with a [redacted] NJ Exec Order 26.4b1.</p> <p>At 1:35 p.m., the surveyor interviewed the Director of Health and Wellness (DHW) and inquired about Resident #1's [redacted] NJ Exec Order 26.4b1 of [redacted] NJ Exec Order 26.4b1 and if the resident was transferred to the hospital for evaluation.</p> <p>The DHW explained that she was not notified of Resident #1's [redacted] NJ Exec Order 26.4b1 on [redacted] NJ Exec Order 26.4b1 when she reviewed the resident's record due to the resident's [redacted] NJ Exec Order 26.4b1. Additionally, the DHW stated that she was unsure why Resident #1 was not sent to the hospital for evaluation on [redacted] NJ Exec Order 26.4b1 following the resident's [redacted] NJ Exec Order 26.4b1. The DHW also confirmed that Resident #1 was not sent to the hospital on [redacted] NJ Exec Order 26.4b1 for evaluation following the [redacted] NJ Exec Order 26.4b1.</p> <p>The surveyor reviewed a facility policy dated 1/2023 and titled, "SUICIDE AND SUICIDE IDEATION RECOGNITION AND GUIDELINES" which revealed under FUNDAMENTAL INFORMATION "Any resident with suicidal ideations must be taken seriously and must undergo a mental health evaluation (either in-house or at another facility/office). Such resident cannot remain in the community ... until the resident is evaluated by a medical health professional and has documentation stating that he/she is not a current danger to him/herself ..."</p>	A 785		

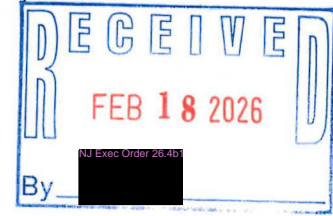


Princeton Junction
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POE #2 Rec'd 2/18/26
Acceptable POE Sent
2/20/26

2/18/2026

Artis Senior Living of Princeton Junction Plan of Correction
Survey Date: 1/6/2026
Statement of Deficiencies Report Date: 2/6/2026



A 310 – 8:36-3.4(a)(1) Administrator’s Responsibilities

NJ Exec Order 26.4b1
Accepted
2/20/26

(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.

The facility failed to follow the **NJ Exec Order 26.4b1** recognition and guidelines for 1 of 3 residents reviewed, Resident #1.

(1) On 1/4/2026 Resident #1 was sent out to the hospital for evaluation and treatment following a **NJ Exec Order 26.4b1**. Resident # 1 was sent to **NJ Exec Order 26.4b1** following is stay at the hospital. Resident #1 was discharged from **NJ Exec Order 26.4b1** back home with family and a **NJ Exec Order 26.4b1**. (2) All residents have the potential to be affected by this deficient practice and therefore the Executive Director (ED) along with the Director of Health and Wellness (DHW) have provided all nurses and medication techs with suicide and suicidal ideation recognition and guideline training on 1/6/26. All staff are receiving the same training and will be completed by 2/28/26 (3) If a resident expresses suicidal ideations to a staff member, that staff member is to notify the nurse on shift immediately. The nurse on shift must assign a care staff to remain with the resident as the nurse on shift notifies the ED, DHW, responsible party (RP), and physician. The nurse on shift is to send the resident to the hospital so further evaluation can be completed. (4) Suicide and suicidal ideation recognition and guideline training will be provided to all new staff during new hire orientation. The ED and/or department directors will be responsible for monitoring this training. The ED and/or department directors will document the monitoring on the employee’s orientation training acknowledgment form.

Completion Date: 2/28/2026

A 401 – 8:36-4.1(a)(22) Resident Rights

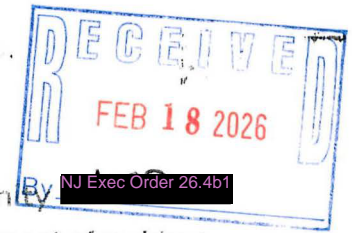
NJ Exec Order
Accepted
2/20/26

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(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.

22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care.

The facility failed to ensure a safe environment while providing care and services for 1 of 3 residents reviewed for [redacted] Resident #1.

(1) On [redacted] at the time of incident [redacted] were immediately relocated so they were not accessible to resident #1. On [redacted] Resident #1 was sent out to the hospital for evaluation and treatment following a [redacted] NJ Exec Order 26.4b1 Resident #1 was sent to [redacted] following his stay at the hospital. Resident #1 was discharged from [redacted] back home with family and a [redacted] (2) All residents have the potential to be affected by this deficient practice and therefore the Executive Director (ED) and Director of Health and Wellness (DHW) have been providing all staff with suicide and suicidal ideation recognition and guidelines training to be completed by 2/28/26. The ED and Director of Environmental Services (DES) held elopement drills on 1/5/26, 1/8/26, and 2/5/26 (3) Elopement, and suicide recognition trainings are being completed with all staff by 2/28/26. All [redacted] in the secure courtyard have been permanently secured to the pavement as of 12/29/25, so they are unable to be moved and used in an unsafe manner. (4) DES will check all [redacted] in the courtyard weekly to ensure they remain secure to the pavement and unable to be moved. Also, Suicide and suicidal ideation recognition training will be provided to all new staff during new hire orientation.

Completion Date: 2/28/2026

[redacted] Accepted
2/20/26

A 475 – 8:36-5.1(h) Types of Services Provided to Residents

(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.

The facility failed to reach and maintain a level of occupancy by Medicaid-eligible persons of at least ten percent (10%) of its total bed amount.

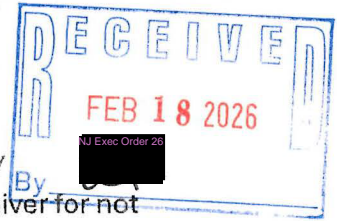
(1) The facility currently has two (2) residents utilizing Medicaid with two (2) residents in Medicaid pending status and two (2) residents in spend down which will be ten percent

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(10%) of the facilities total bed amount. The facility will be applying for a waiver for not maintaining 10% of Medicaid eligible residents (2) All residents have the potential to be affected by this deficient practice and therefore the ED and Director of Business Services (DBS) will send out required financial updates for each resident who has resided at the facility for at least six (6) months so the facility can capture a residents need for Medicaid in a timely manner. (3) If the facility drops below the required 10%, the ED and/or DBS will initiate the waiver application for not maintaining the 10% requirement. Additionally, the ED and/or DBS will reach out to sister communities in NJ to offer Medicaid available beds to residents who are eligible. The ED and/or DBS will send communication to all responsible parties (RP's) pertaining to Medicaid eligibility and requirements. (4) The ED and/or DBS will monitor census daily to capture any occupancy changes regarding residents utilizing Medicaid. Additionally, the ED and DBS will create and use a Medicaid tracker to monitor residents who have an upcoming need for Medicaid.

Completion Date: 3/31/2026

A 537 – 8:36-5.7(a)(1) Policy and Procedure Manual

Accepted
2/20/26

(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 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.

The facility failed to review its policies and procedures in accordance with N.J.A.C 8:36-5.7, which required that all policies be reviewed at least annually and that such review is documented.

(1) All facility policies and procedures are under review by the ED and designee and will be completed by 2/28/2026. (2) All residents have the potential to be effected by this deficient practice and therefore the ED and/or Artis Senior Living designee will conduct a documented review of all policies and procedures annually to ensure compliance among staff. (3) The facility ED and/or Artis Senior Living designee will conduct a review annually and document the review by signing and dating a review acknowledgment sheet. Additionally, revisions to policies and/or procedures will be notated and dated on the review acknowledgment sheet. (4) The ED and/or designee will have a calendar tracker in

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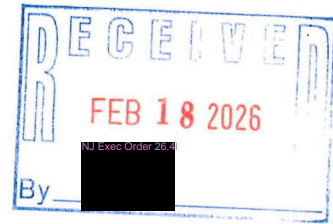
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place that will provide notification upon due date of the policies and procedures annual review.

Completion Date: 2/28/2026



A 563 – 8:36-5.10(a)(2) Reportable Events

(a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 or (609) 392-2020 if after business hour, followed within 72 hours by written confirmation, of the following

2. Any elopements; and

Accepted 2/20/26.

The facility failed to notify the Department of Health (DOH) of a [redacted NJ Exec Order 26.4b1] by a resident immediately by telephone for 1 of 3 residents, Resident #1.

(1) Reportable incident on [redacted NJ Exec Order 26.4b1] was reported to the Department of Health in writing on [redacted NJ Exec Order 26.4b1]. The ED asked the department representative what category the reportable incident would fall under to ensure the document was completed properly as [redacted NJ Exec Order 26.4b1] is not listed. There was miscommunication as the ED was trying to ascertain the correct reporting category and at no time felt the incident did not require reporting. (2) All residents have the potential to be affected by this deficient practice and therefore the ED and/or designee will continue to send reportable incidents to the Department of Health as required to ensure regulatory compliance and oversight. (3) Upon receiving a report of a "significant event," the ED and/or designee will immediately notify the Department of Health by telephone followed by a written confirmation within 72 hours. (4) The ED and designee will maintain the department's telephone number for reportable incidents (800-792-9770) in their cell phones, so the numbers are always accessible to them in the event of a "significant reportable event."

Completion Date: 1/5/2026

Accepted 2/29/26.

A 745 – 8:36-7.2(f) Health Care Assmnt. and Health Service Plan

(f) The initial health care assessment shall be documented by the registered nurse and shall be updated as required, in accordance with the rules of this chapter and professional standards of practice.

The facility failed to ensure a comprehensive assessment was completed by a Registered Nurse (RN) upon a resident's admission to the facility for 1 of 3 residents, Resident #1.

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(1) Resident #1's health care assessment was conducted on [redacted] NJ Exec Order 26.4b1. The assessment was entered into the facilities electronic health record (EHR) system and completed on [redacted] NJ Exec Order 26.4b1. (2) All residents have the potential to be affected by this deficient practice and therefore the ED and Director of Health and Wellness (DHW) will audit all current resident charts to ensure all residents have had an initial assessment completed upon admission to the facility. Audit will be completed by 3/1/2026 (3) The ED and/or DHW will document the chart audit for initial assessment dates and sign and date the audit verifying completion. (4) All new residents upon admission will have a health care assessment completed by a Registered Nurse (RN) and entered in the facilities EHR system either prior to, or upon residents' physical move in. A resident's physical move in will not occur until the health care assessment has been entered and completed in the facilities EHR system.

Completion Date: 3/1/2026

A 779 – 8:36-7.5(c) Provision of Health Care Services

[redacted] NJ Exec Order 26.4b1 Accepted
2/20/26

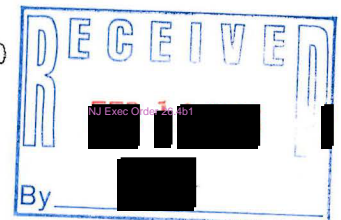
(c) The registered professional nurse shall be called at the onset of illness, injury or change in condition of any resident to arrange for assessment of the resident's nursing care needs or medical needs and for needed nursing care interventions or medical care.

The facility failed to notify a registered nurse (RN) of a change in condition when resident [redacted] NJ Exec Order 26.4b1 for 1 of 3 residents, Resident #1.

(1) On [redacted] NJ Exec Order 26.4b1 the DHW was notified of Resident #1's [redacted] NJ Exec Order 26.4b1. Or [redacted] NJ Exec Order 26.4b1 in Resident #1 was sent out to the hospital for evaluation and treatment [redacted] NJ Exec Order 26.4b1 in [redacted] NJ Exec Order 26.4b1. (2) All residents have the potential to be affected by this deficient practice and therefore the ED and DHW have been providing all LPN's and Medication Techs with suicide and suicidal ideation recognition and guidelines training to be completed by 2/28/26 with the expectation and understanding that the DHW will be notified immediately if a resident expresses suicidal ideations. (3) If a resident expresses suicidal ideations to an LPN or Medication Tech, or if a staff member reports to an LPN or Med Tech of a resident's suicidal ideations, the LPN or Med Tech receiving the report will report to the DHW immediately and follow guidelines of the facilities suicide and suicidal ideation recognition and guidelines policy and procedure. (4) Suicide and suicidal ideation recognition and guideline training will be provided to all current staff and all new staff during new hire orientation. The ED and/or department directors will be responsible for monitoring this training. The ED and/or department directors will document the monitoring on the employee's orientation training acknowledgment form.

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Princeton Junction
A Memory Care Community

Completion Date: 2/28/2026

NJ Exec Order 26.4
Accepted
2/20/26

A 781 – 8:36-7.5(d) Provision of Health Care Services

(d) The resident’s physician or physician’s designee, that is, another physician or an advanced practice nurse or physician assistant, shall be notified by the licensed professional nurse of any significant changes in the resident’s physical or cognitive/mental condition and any intervention by the physician shall be recorded.

The facility failed to notify the physician of a resident’s NJ Exec Order 26.4b1 for 1 of 3 residents, Resident #1.

(1) On NJ Exec Order 26.4b1 Resident #1’s physician was notified of the resident’s NJ Exec Order 26.4b1. On

NJ Exec Order 26.4b1 Resident #1 was sent out to the hospital for evaluation and treatment following a

NJ Exec Order 26.4. (2) All residents have the potential to be affected by this deficient practice and therefore the ED and DHW have been providing all LPN’s and Medication Techs with suicide and suicidal ideation recognition and guidelines training to be completed by 2/28/26 with the expectation and understanding that a resident’s physician will be notified immediately if a resident expresses suicidal ideations. (3) If a resident expresses suicidal ideations to an LPN or Medication Tech, or if a staff member reports to an LPN or Med Tech of a resident’s suicidal ideations, the LPN or Med Tech receiving the report will notify the resident’s physician immediately and follow guidelines of the facilities suicide and suicidal ideation recognition and guidelines policy and procedure. (4) Suicide and suicidal ideation recognition and guideline training will be provided to all current staff and all new staff during new hire orientation. The ED and/or department directors will be responsible for monitoring this training. The ED and/or department directors will document the monitoring on the employee’s orientation training acknowledgment form.

Completion Date: 2/28/2026

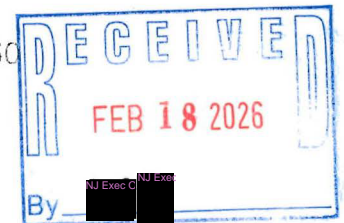
NJ Exec Order 26.4
Accepted
2/20/26

A 785 – 8:36-7.5(f) Provision of Health Care Services

(f) If it is determined that there is a medical need for a transfer of a resident to another health care facility because the assisted living residence, comprehensive personal care home or assisted living program cannot meet the resident’s needs, such transfer shall be initiated promptly, in accordance with N.J.A.C 8:36-5.1(d). The registered professional nurse shall be notified to ensure that the resident is receiving appropriate care during the transfer period.

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By NJ Exec C NJ Exec

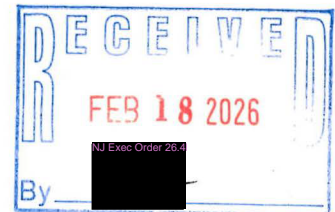


Princeton Junction
A Memory Care Community

The facility failed to transfer resident to the hospital for evaluation for 1 of 3 residents, Resident #1.

(1) On [redacted] Resident #1 was sent out to the hospital for evaluation and treatment following a [redacted] NJ Exec Order 26.4b1. Resident # 1 was sent to [redacted] NJ Exec Order 26.4b1 following is stay at the hospital. Resident #1 was discharged from [redacted] NJ Exec Order 26.4b1 back home with family and a [redacted] NJ Exec Order 26.4b1. (2) All residents have the potential to be affected by this deficient practice and therefore the ED and DHW have been providing all LPN's and Medication Techs with suicide and suicidal ideation recognition and guidelines training to be completed by 2/28/26 with the expectation and understanding that a resident must be transferred to the hospital immediately if he/she expresses suicidal ideations. (3) If a resident expresses suicidal ideations to an LPN or Medication Tech, or if a staff member reports to an LPN or Med Tech of a resident's suicidal ideations, the LPN or Med Tech receiving the report will follow the guidelines of the facilities suicide and suicidal ideation recognition and guidelines policy and procedure and immediately have the resident transferred to the hospital for evaluation. (4) Suicide and suicidal ideation recognition and guideline training will be provided to all current staff and all new staff during new hire orientation. The ED and/or department directors will be responsible for monitoring this training. The ED and/or department directors will document the monitoring on the employee's orientation training acknowledgment form.

Completion Date: 2/28/2026



NJ Exec Order 26.4b1

2/18/2026

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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 11A013 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 2/20/2026 Y3
NAME OF FACILITY ARTIS SENIOR LIVING OF PRINCETON JUNCTION		STREET ADDRESS, CITY, STATE, ZIP CODE 861 ALEXANDER ROAD PRINCETON, NJ 08540

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 A0401	Correction	ID Prefix A0475	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-5.1(h)	Completed
LSC	02/28/2026	LSC	02/28/2026	LSC	03/31/2026
ID Prefix A0537	Correction	ID Prefix A0563	Correction	ID Prefix A0745	Correction
Reg. # 8:36-5.7(a)(1)	Completed	Reg. # 8:36-5.10(a)(2)	Completed	Reg. # 8:36-7.2(f)	Completed
LSC	02/28/2026	LSC	01/05/2026	LSC	03/01/2026
ID Prefix A0779	Correction	ID Prefix A0781	Correction	ID Prefix A0785	Correction
Reg. # 8:36-7.5(c)	Completed	Reg. # 8:36-7.5(d)	Completed	Reg. # 8:36-7.5(f)	Completed
LSC	02/28/2026	LSC	02/28/2026	LSC	02/28/2026
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/6/2026		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 11A013	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 2/20/2026
NAME OF FACILITY ARTIS SENIOR LIVING OF PRINCETON JUNCTION	STREET ADDRESS, CITY, STATE, ZIP CODE 861 ALEXANDER ROAD PRINCETON, NJ 08540	

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).

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LSC	02/28/2026	LSC	02/28/2026	LSC	02/28/2026
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
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