

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/21/2025
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NAME OF PROVIDER OR SUPPLIER CARNEGIE ASSISTED LIVING AT PRINCETON	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WINDROW DRIVE PRINCETON, NJ 08540
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A 000	<p>Initial Comments</p> <p>Initial Comments: COMPLAINT #: NJ 00176668 and NJ 00189114</p> <p>CENSUS: 69</p> <p>SAMPLE SIZE: 6</p> <p>TYPE OF SURVEY: Standard and Complaint Survey</p> <p>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.</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) Administration</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

01/15/26

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: Complaint #: NJ 00189114</p> <p>Based on facility policy review, record review, facility document review, and interview, the facility failed to ensure they implemented and their policy for physician order entries into electronic medical records (EMRs), which affected 1 (Resident #2) of 3 residents reviewed for [redacted] Specifically, the facility staff were not aware that the Nurse Practitioner (NP) entered an order for a [redacted] evaluation and treatment, which caused a four-week delay in treatment for the resident.</p> <p>Findings included:</p> <p>A facility policy titled, "Physician Order," revised 12/2024, revealed, "Physician orders are handled in accordance with applicable legal requirements and acceptable standards of practice." The policy further revealed, "All physician orders shall be entered into the [electronic health record] promptly upon receipt and forwarded to the appropriate service provider (e.g. [exempli gratia; for example], pharmacy, therapy department, laboratory, radiology provider, hospice agency, etc. [et cetera; and so forth]) for timely implementation in accordance with facility procedures and regulatory requirements."</p> <p>A facility policy titled, "Community Designated Pharmacy," dated 01/2025, revealed, "The Licensed Nurse or designee notifies the</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>pharmacy of the resident and forwards the Resident Information, Insurance information, and Prescriptions to the pharmacy for new orders to be entered by the pharmacist following the pharmacy-driven contract for new and existing residents."</p> <p>An "Admission Record" revealed the facility admitted Resident #2 on [redacted] NJ Exec Order 26.4b1. According to the Admission Record, the resident had a medical history that included diagnoses of [redacted] NJ Exec Order 26.4b1.</p> <p>Resident #2's "Progress Notes" indicated that the resident was admitted to a hospital on [redacted] NJ Exec Order 26.4b1 related to having [redacted] NJ Exec Order 26.4b1 and having [redacted] NJ Exec Order 26.4b1 and [redacted] NJ Exec Order 26.4b1.</p> <p>Resident #2's [redacted] NJ Exec Order 26.4b1 Discharge Summary," for the timeframe from [redacted] NJ Exec Order 26.4b1 through [redacted] NJ Exec Order 26.4b1 revealed that Resident #2 was discharged from [redacted] NJ Exec services on [redacted] NJ Exec Order 26.4b1. The record revealed that the resident was being discharged to this facility with recommendations that included [redacted] NJ Exec Order 26.4b1, and for morning and evening "assistance/caregiver." The record revealed that the resident required [redacted] NJ Exec Order 26.4b1 for [redacted] NJ Exec Order 26.4b1, and [redacted] NJ Exec Order 26.4b1 with a [redacted] NJ Exec Order 26.4b1. The discharge instructions revealed that it did not include a continuation of [redacted] NJ Exec Order 26.4b1 services.</p> <p>Resident #2's [redacted] NJ Exec Order 26.4b1 Discharge Summary," for the timeframe from [redacted] NJ Exec Order 26.4b1 through [redacted] NJ Exec Order 26.4b1 revealed Resident #2 was discharged from [redacted] NJ Exec services on [redacted] NJ Exec Order 26.4b1. The record revealed that the resident was being discharged to this facility with recommendations that included [redacted] NJ Exec Order 26.4b1 bearing as</p>	A 310		
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A 310	<p>Continued From page 3</p> <p>[REDACTED] and for morning and evening "assistance/caregiver." The record revealed that the resident required assistance with [REDACTED]) and [REDACTED] for safety and indicated that [REDACTED] was ordered that included a standard wheelchair and a [REDACTED]. The discharge instructions revealed that it did not include a continuation of [REDACTED] services.</p> <p>Resident #2's "Progress Notes" indicated that the facility readmitted the resident from a [REDACTED] facility on [REDACTED]</p> <p>An "IDT [Interdisciplinary Team] Team Incident Investigation Summary," dated [REDACTED] revealed Resident #2 was [REDACTED] on [REDACTED] at 12:45 PM. The document indicated that the resident stated that they were trying to get ready to go to lunch. The document indicated that staff re-educated the resident on using their [REDACTED] to call for assistance and indicated that staff were to provide [REDACTED] for the resident prior to scheduled meals.</p> <p>Resident #2's "Progress Notes" revealed a note, dated [REDACTED] at 1:44 PM and electronically signed by the NP, that revealed that Resident #2 had a history of [REDACTED], including a [REDACTED] that day [REDACTED]). The note indicated that the resident's history of [REDACTED] was causing [REDACTED] and [REDACTED]</p> <p>Resident #2's "Order Recap [Recapitulation] Report," for the timeframe from [REDACTED] through [REDACTED], revealed an order dated [REDACTED] consultation to evaluate and treat Resident #2.</p> <p>Resident #2's "Order Details," dated [REDACTED]</p>	A 310		
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A 310	<p>Continued From page 4</p> <p>revealed that the NP "Created" the order for a NJ Exec Order 26.4b1 in the EMR on NJ Exec Order 26.4b1 at 10:13 PM and "Confirmed" and revised the order on the same date and at the same time.</p> <p>Resident #2's EMR revealed a handwritten physician's prescription for a NJ Exec Order 26.4b1 evaluation and treatment, dated NJ Exec Order 26.4b1.</p> <p>Resident #2's NJ Exec Order 26.4b1 Evaluation & Plan of Treatment" revealed that the evaluation was conducted and NJ Exe started on NJ Exec Order 26.4b1, 33 days after the initial order.</p> <p>Resident #2's records revealed no evidence of an NJ Exec Order 26.4b1 evaluation following the NJ Exec Order 26.4b1 order prior to NJ Exec Order 26.4b1.</p> <p>During a telephone interview on 11/2/2025 at 12:39 PM, Resident #2's family member (FM), FM #1, stated that it was their understanding that NJ Exec Order 26.4b1 was supposed to start when Resident #2 was discharged from the hospital after NJ Exec Order 26.4b1 and continue as NJ Exec Order 26.4b1 two to three times a week. FM #1 stated that Resident #2 went to NJ Ex Order 26.4(b)(1) after the hospital stay and was there for 18 days. FM #1 stated that they did not know why the referral for NJ Exec Order 26.4b1 had not been acted on. FM #1 stated that they asked the facility staff for a NJ Exec Order 26.4b1 schedule. FM #1 stated that facility staff said they did not have a schedule for the resident due to no orders for NJ Exec Order 26.4b1. FM #1 stated that the Director of Rehabilitation (DOR) told them that Resident #2 was not one of their patients. FM #1 stated that prior to Resident #2 being readmitted to the facility, they had a call to ensure the facility could meet the resident's needs and felt they discussed the resident would be continuing NJ Exec</p>	A 310		

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A 310	<p>Continued From page 5</p> <p>During a telephone interview on 11/20/2025 at 1:01 PM, the NP stated that she did remember Resident #2, and that the resident had been experiencing a large number of [redacted] NJ Exec Or She stated that she ordered [redacted] NJ Exec Order for Resident #2. In regard to her expectations for orders to be carried out, she stated, "It is my understanding was whatever the protocol is. I don't know what their protocol was."</p> <p>During a telephone interview on 11/20/2025 at 1:37 PM, the DOR stated that once [redacted] NJ Exec Order 26 staff received a prescription from a physician, they scheduled the resident for an evaluation. She stated that the completion of the evaluations was dependent on how long it took to get the prescription. She stated that if the resident transferred from [redacted] NJ Ex Order 26 to this facility, the physician at the [redacted] NJ Ex Order would most likely automatically write out a prescription for [redacted] NJ Exec Order 2 to continue. The DOR stated that if the resident was already at this facility, then it was up to the ordering physician. She stated that she did remember Resident #2 vaguely. She stated that the resident was there for [redacted] NJ Ex Order 26.4(b)(1)</p> <p>During an interview on 11/21/2025 at 6:17 AM, Licensed Practical Nurse (LPN) #3 stated that when an order for a medication was received, she checked the resident's EMR to confirm it in the record. She stated that she thought that the physician sent a prescription to the pharmacy. She stated that she had never dealt with a [redacted] NJ Ex order but assumed it would be handled the same way.</p> <p>During an interview on 11/21/2025 at 7:36 AM, LPN #2 stated that the NP told them when she wrote an order, then the nurses checked the</p>	A 310		

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A 310	<p>Continued From page 6</p> <p>pending orders in the EMR and confirmed the new orders in the record. She stated that she did not know what the expectation was for how long it should take for an evaluation once [redacted] was ordered. She stated that if it was on her shift, she tried to get them confirmed and if not, she told the oncoming staff. She stated that she did not have an answer for how to handle a [redacted] order and would have to ask the Director of Resident Care (DRC) for direction.</p> <p>During an interview on 11/21/2025 at 8:10 AM, LPN #4 stated that when they received an order from a physician, the nurses had to confirm the order in the EMR, then the order would show in pending orders. He stated that when a physician gave an order, they should also give a prescription. He stated that for [redacted] orders, after they received the prescription and faxed it to the pharmacy, they took the prescription to the front desk for the [redacted] staff to retrieve from the [redacted] binder. He stated that the physician was responsible for writing the prescriptions, including orders for [redacted]. He stated that if he was aware of something that needed to be followed up on, he would come the next day and check the EMR for the pending orders. He stated that the nurses were responsible for making sure therapy was started. He stated that if they had not received a prescription from the physician or NP after receiving verbal orders, they should be contacting them in less than 24 hours to follow up.</p> <p>During an interview on 11/21/2025 at 9:45 AM, the DRC stated that facility staff did not enter orders into the EMR; they had to send all orders to the pharmacy, even for ancillary orders such as referrals to [redacted]. She stated that they called the physician or NP to ask for a prescription, then staff sent the prescription to the pharmacy for</p>	A 310		

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A 310	<p>Continued From page 7</p> <p>them to enter it into the EMR, scanned it, and placed it in the [redacted] binder at the front desk. The DRC stated that [redacted] staff then picked up the prescription and took it from there. Per the DRC, the NP had been told numerous times that she could not enter and confirm her own orders in the record because the pharmacy entered all the orders except the [redacted] orders. She stated that she received a call from FM #1 on [redacted]. She stated that FM #1 wanted the resident to start [redacted] and the NP wrote a prescription on [redacted] for [redacted]. She stated that facility staff did review the NP's progress notes but did not always know who she saw unless they met with her before she left the facility. She stated that she could not speak for what was written in the NP's progress notes or [redacted] as she was not employed with the facility at that time. She stated that the NP did speak with her and reviewed her notes and provided orders, but she was not sure what was happening before she began employment. The DRC stated that once the pharmacy staff entered the new orders from the prescription, the floor nurses saw the pending orders in the EMR, and once they saw orders, they confirmed them in the record. She stated that had the NP followed the process, someone would have seen the order and the order would have been carried out the first part of [redacted].</p> <p>During an interview on 11/21/2025 at 10:07 AM, the Executive Director (ED) stated that the NP should not enter orders into their EMR. She stated that if staff did not send the order prescription form, then staff could not confirm it in the record, and the order would not show up as an active order. She stated that the pharmacy staff entered the orders when they received the prescription. The ED stated that the NP should</p>	A 310		

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A 310	Continued From page 8 not be entering and confirming any orders in residents' EMRs. The ED stated that facility staff did not talk to her about the issue involving Resident #2 but did call her about another situation that was similar. The ED stated that as soon as the staff received a prescription, they should send it to [NJ Exec Order 26] staff, and [NJ Exec Order 26] staff should start as soon as possible after evaluation. The ED stated that there were times it could even take a week depending on their workflow. She stated that as soon as they were aware of the [NJ Exec Order 26] order not being followed, they talked to the family. She stated that what she thought happened was that the Resident #2's family expected Resident #2 to continue [NJ Exec Order 26] once the resident returned from the [NJ Ex Order 26.4(b)(1)] facility, but they did not receive a prescription during transfer. She stated that facility staff were not aware of the NP's order. She stated that after the resident's family talked to the DRC, she reached out to the NP or [NJ Exec Order 26.4b1] and got a prescription. The ED stated that if the NP had communicated to them, the family would not have had to.	A 310		
A 749	8:36-7.3(a) Resident Assessments and Care Plans (a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.	A 749		

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A 749	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to revise a service plan for 1 (Resident #1) of 6 sampled residents. Specifically, the facility failed to update Resident #1's service plan after the resident was approved to <u>NJ Exec Order 26.4b1</u> medications.</p> <p>Findings included:</p> <p>An undated facility policy titled, "Health Care Plan" revealed, "Policy: To implement a Health Care plan for a resident when a health issue occurs that will not be resolved within 14 days. The community shall ensure, either directly or indirectly; [sic] that the health care service needs of residents are met. To establish an evaluation, treatment and positive outcome process to ensure comprehensive management of the resident's health care issue(s) until resolved." The policy further revealed, "2. Services shall be provided to prevent clinically avoidable complication, including: a. Pressure ulcer development b. Contractures c. Loss of continence d. Dehydration e. Malnutrition f. Other as needed 3. The Director of Resident Care or RN [registered nurse] designee will complete and evaluation of the resident to determine need to the Health Plan." The policy specified, "5. A Health Care Plan will be developed that will include the health issues; orders for treatment or services, medication, and diet, if needed, the resident's needs and preferences for himself or herself and the specific goal of treatment or services. The Health Care plan will be administered under the direction of the Registered Professional Nurse. 6. The Resident's progress will be assessed by the Director of Resident Care on a quarterly basis (90 days)</p>	A 749		

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A 749	<p>Continued From page 10 and/or revised as needed."</p> <p>Resident #1's "Admission Record" revealed the facility admitted the resident on [redacted] NJ Exec Order 26.4b1. According to the Admission Record, the resident had a medical history that included a diagnosis of [redacted] NJ Exec Order 26.4b1) and [redacted] NJ Exec Order 26.4b1.</p> <p>Resident #1's "Order Summary Report" included an active order dated [redacted] NJ Exec Order 26.4b1 for [redacted] NJ Exec Order 26.4b1 to be applied to [redacted] NJ Exec Order 26.4b1 twice daily. The order specified that the resident could [redacted] NJ Exec Order 26.4b1 this medication. The Order Summary Report also included an active order dated [redacted] NJ Exec Order 26.4b1 for [redacted] NJ Exec Order 26.4b1 to be applied to affected [redacted] NJ Exec Order 26.4b1 twice daily until healed. The order specified that the resident could [redacted] NJ Exec Order 26.4b1 this medication.</p> <p>Resident #1's "Service Plan Report" revealed no information regarding the resident's ability to [redacted] NJ Exec Order 26.4b1 their [redacted] NJ Exec Order 26.4b1 [redacted].</p> <p>During an interview on 10/31/2025 at 12:45 PM, the Director of Resident Care (DRC) stated she expected [redacted] NJ Exec Order 26.4b1 of medications to be included in a resident's service plan. She stated that she had only been employed at the facility for [redacted] NJ Exec Order 26.4b1 and was trying to work on service plans as time allowed.</p>	A 749		
A 935	<p>8:36-11.4(b) Pharmaceutical Services</p> <p>(b) All medications shall be administered by qualified personnel in accordance with prescriber orders, facility or program policy, manufacturer's</p>	A 935		

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A 935	<p>Continued From page 11</p> <p>requirements, cautionary or accessory warnings, and all Federal and State laws and regulations.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00176668</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure 1 (Resident #1) of 6 sampled residents received medications in accordance with providers' orders.</p> <p>Findings included:</p> <p>A facility policy titled, "Medication Administration," reviewed 01/2025, revealed, "5. Accuracy- The Rights of Med [medication] Pass a. Right Patient b. Right Drug- Compare the pharmacy label/package to the MAR [medication administration record]/eMar [electronic medication administration record]- the medication and strength must match exactly what is ordered c. Right Dose- Ensure that the number of tablets is equivalent to the ordered amount."</p> <p>Resident #1's "Admission Record" revealed the facility admitted the resident on NJ Exec Order 26.4b1. According to the Admission Record, the resident had a medical history that included a diagnosis of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.</p>	A 935		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/21/2025
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NAME OF PROVIDER OR SUPPLIER CARNEGIE ASSISTED LIVING AT PRINCETON	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WINDROW DRIVE 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 935	<p>Continued From page 12</p> <p>During an interview on 10/30/2025 at 11:21 AM, Resident #1 reported they did not always receive their medications as ordered.</p> <p>Resident #1's "Order Summary Report" included an order dated [redacted] for [redacted], one tablet of each [redacted] component twice daily for 5 days, to start on [redacted] and end on [redacted].</p> <p>Resident #1's [redacted] MAR revealed transcription of the order for [redacted] twice daily for five days to start on [redacted]. However, despite the order specifying that the medication was to be given for five days, the MAR reflected that the administration of [redacted] was only scheduled to be administered for four days. Documentation on the MAR indicated staff administered the [redacted] as ordered on [redacted] for a total of four days instead of five days as ordered by the physician.</p> <p>Resident #1's "Progress Notes" revealed a note dated [redacted] at 9:19 PM that indicated the resident returned from a [redacted] appointment, and [redacted] were performed during the visit. The note indicated the physician prescribed a [redacted].</p> <p>Resident #1's "Order Summary Report" included an order dated [redacted] applied to affected [redacted] twice daily until healed. The order specified the resident could [redacted] the medication.</p> <p>Resident #1's [redacted] MAR revealed</p>	A 935		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/21/2025
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NAME OF PROVIDER OR SUPPLIER CARNEGIE ASSISTED LIVING AT PRINCETON	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WINDROW DRIVE 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 935	<p>Continued From page 13</p> <p>transcription of the order for NJ Exec Order 26.4b1 twice daily until healed to start on NJ Exec Order 26.4b1. The MAR revealed application of the medication was scheduled for 9:00 AM and 6:00 PM each day, beginning on NJ Exec Order 26.4b1. However, there was no documentation on the MAR to indicate the medication was administered on NJ Exec Order 26.4b1 and the MAR was coded with a NJ Exec Order 26.4b1 for "Other/See Nurse Note" for the application scheduled for 9:00 AM on NJ Exec Order 26.4b1.</p> <p>Resident #1's "Progress Notes" revealed an "eMAR- Medication Administration Note," dated NJ Exec Order 26.4b1 at 1:50 PM, that indicated the facility was "awaiting order" for the resident's NJ Exec Order 26.4b1.</p> <p>During an interview on 10/30/2025 at 11:21 AM, Resident #1 stated their provider prescribed an NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 for application to NJ Exec Order 26.4b1 on their NJ Exec Order 26.4b1 but they did not receive the medication until two days later.</p> <p>During an interview on 10/31/2025 at 5:34 PM, the Director of Resident Care reported that the pharmacy delivered medications several times during the day, and there should not be any missed doses of medications. She stated she was not sure why Resident #1 missed doses of their medication.</p> <p>During an interview on 10/31/2025 at 3:45 PM, the Executive Director stated she expected staff to follow providers' orders for medication administration.</p>	A 935		
A1289	8:36-18.2(d) Infection Prevention and Control Services	A1289		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/21/2025
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NAME OF PROVIDER OR SUPPLIER CARNEGIE ASSISTED LIVING AT PRINCETON	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WINDROW DRIVE 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
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A1289	<p>Continued From page 14</p> <p>(d) The facility shall document evidence of vaccination against pneumococcal disease for all residents who are 65 years of age or older, in accordance with the General Recommendations on Immunization of the Advisory Committee on Immunization Practices of the Centers for Disease Control, February 8, 2002, incorporated herein by reference, as amended and supplemented, unless such vaccination is medically contraindicated or the resident has refused offer of the vaccine in accordance with N.J.A.C. 8:36-4.1(a). The General Recommendations on Immunization of the Advisory Committee on Immunization Practices of the Centers for Disease Control, February 8, 2002, which are available on the Internet at http://www.cdc.gov/nip/publications/acip-list.htm. The facility shall provide or arrange for pneumococcal vaccination of residents who have not received this immunization, prior to or on admission unless the resident refuses offer of the vaccine.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide or arrange for [NJ Exec Order 26.4b1] against [NJ Exec Order 26.4b1] despite having no documentation that the [NJ Exec Order 26.4b1] was previously received or contraindicated for 1 (Resident #1) of 6 residents reviewed for [NJ Exec Order 26.4b1]</p> <p>Findings included:</p> <p>A facility policy titled, "Resident Immunization -Pneumococcal Vaccine," reviewed 01/2025, revealed, "Purpose: To reduce pneumococcal infections, pneumococcal vaccine is being offered</p>	A1289		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/21/2025
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NAME OF PROVIDER OR SUPPLIER CARNEGIE ASSISTED LIVING AT PRINCETON	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WINDROW DRIVE 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
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A1289	<p>Continued From page 15</p> <p>to all residents. Pneumovax will be given to high risk residents who have not had it before. These include people 65 and older, the very young and people with special health issues such as alcoholism, heart or lung disease, kidney failure, diabetes, HIV infection, or certain types of cancer."</p> <p>Resident #1's "Admission Record" revealed the facility admitted the resident on [NJ Exec Order 26.4b1]. According to the Admission Record, the resident had a medical history that included diagnosis of [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1]. The section of the Admission Record titled, "Other Information" included an area to record "[NJ Exec Order 26.4b1] Date;" however, this area was blank.</p> <p>During an interview on 10/31/2025 at 2:06 PM, Resident #1 revealed they had signed a consent form to receive the [NJ Exec Order 26.4b1] when they were admitted to the facility but had yet to receive the [NJ Exec Order 26.4b1]. Resident #1 reported they wished to receive the [NJ Exec Order 26.4b1].</p> <p>Resident #1's "Consent for [NJ Exec Order 26.4b1] form, signed by Resident #1 on [NJ Exec Order 26.4b1], revealed Resident #1 authorized the administration of the [NJ Exec Order 26.4b1].</p> <p>Resident #1's electronic medical record and "[NJ Exec Order 26.4b1] Report," dated [NJ Exec Order 26.4b1], revealed no documentation that Resident #1 received the [NJ Exec Order 26.4b1] while a resident of the facility or that the [NJ Exec Order 26.4b1] was contraindicated or previously received.</p> <p>During an interview on 10/31/2025 at 12:45 PM, the Director of Resident Care stated the</p>	A1289		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/21/2025
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NAME OF PROVIDER OR SUPPLIER CARNEGIE ASSISTED LIVING AT PRINCETON	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WINDROW DRIVE 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
A1289	Continued From page 16 NJ Exec Order 26.4b1 should have been given to Resident #1 when the consent was obtained and documented in the electronic health record. During an interview on 10/31/2025 at 3:45 PM, the Executive Director stated she would have expected the NJ Exec Order 26.4b1 to have been administered when it was offered.	A1289		
A1249	8:36-17.7 Building and Grounds Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the building was kept in good condition and free from hazards to residents health and safety. This deficient practice was evidenced by the following: On 10/30/25 at 9:20 a.m., upon entering the common room for entrance conference, the	A1249		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/21/2025
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NAME OF PROVIDER OR SUPPLIER CARNEGIE ASSISTED LIVING AT PRINCETON	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WINDROW DRIVE 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
A1249	<p>Continued From page 17</p> <p>surveyor observed water damage on the ceiling with a black, mold-like substance stain.</p> <p>At 11:11 a.m. the surveyor toured the first floor with the Director of Maintenance (DOM) and observed water damage on the ceiling with a black, mold-like substance stain in the resident lounge.</p> <p>At 11:15 a.m., in the presence of the DOM, the surveyor observed water damage by a ceiling light with a mold-like substance stain in the bar area of the first floor. Additionally, the surveyor observed water damage with a mold-like substance stain above the bar.</p> <p>At 11:30 a.m., the surveyor interviewed the DOM regarding the above ceiling stains. The DOM stated that he was aware of the issue and that he noticed the ceiling stains in September of 2025. The DOM explained that one of the cooling pipes of the Air Conditioning system had leaked onto the ceiling and that the facility was currently working with a contractor to fix the issues.</p>	A1249		



POC# | received 1/15/26
Accepted 1/20/26
1000 Windrow Drive, Princeton, NJ 08540
(609) 514-9111

Carnegie Senior Living
PLAN OF CORRECTION (POC)

A310 Complaint Visit 11/21/2025

How the corrective action will be accomplished for those residents found to be affected by this practice?

- *Residents #2 is no longer residing at the community; therefore, no direct corrective action could be implemented for that resident.*
- *All residents' Medical Records were audited by the clinical team to see if any other residents had orders entered by physicians without following community protocol. Audit started on 11/24/2025 and finished on 11/28/2025.*

How the Facility will identify other residents having the potential to be affected by the same deficient practice?

- *All Residents who live in the facility have the Potential to be affected.*

What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur?

- *Doctor's orders Protocol: The executive director educated medical providers on 11/24/2025 - 11/28/2025 in regards to the company policy. Starting on 11/28/2025, medical providers are not to enter any orders directly into the Electronic medical records (EMR'S) , instead send orders to the pharmacy.*
- *Doctor's order Audit: Director of Resident Care in collaboration with pharmacy representatives have implemented a Weekly order audit to avoid errors or delays in carrying our physicians orders.*

How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?)

- *The Executive Director or designee will conduct a monthly audit of 5 resident charts to ensure that all orders are being carried out. Monthly x3 and quarterly thereafter x3 starting on 12/21/2025.*
- *Audit Results will be reviewed monthly during the Quality Improvement (QI) meeting starting on 12/21/2025 by the Interdisciplinary Team IDT team.*

Completion Date: 11/29/2025

NJ Exec Order 26.4

approved
1/20/26



Carnegie Senior Living
PLAN OF CORRECTION (POC)

A 749 Complaint Visit 11/21/2025

How the corrective action will be accomplished for those residents found to be affected by this practice?

- Resident #1 continues to reside in the community. Resident #1's clinical record, physician orders, and service plan were immediately updated to reflect the resident's approved ability to NJ Exec Order 26.4b1 medications in accordance with physician orders and facility policy.
- An audit started on 10/31/2025 and was completed on 11/2/2025 for all residents who self administer medications. The updated service plans now clearly identify all required information.

How the Facility will identify other residents having the potential to be affected by the same deficient practice?

- All Residents who live in the facility have the Potential to be affected.

What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur?

- On 10/31/25 the Executive Director conducted an in-service provided to the Director of Resident Care and clinical team regarding assessment, service plan revision requirements, and regulations.
- The Regional Nurse reviewed policies and responsibilities on 11/02/2025 with the Director of Resident Care to ensure service plans are updated promptly following changes in medication administration status.

How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?)

- The Director of Resident Care or designee will conduct monthly audits of residents approved for self-administration of medications for a period of six (6) months, starting 11/3/2025, to verify that service plans accurately reflect self-administration status.
- Audit Results will be reviewed monthly during the Quality Improvement (QI) meeting starting on 12/21/2025 by the Interdisciplinary Team IDT team.

Completion Date: 11/29/2025

NJ Exec Order 26.4b1

approved
1/20/26



Carnegie Senior Living
PLAN OF CORRECTION (POC)

A 935 Annual Survey 11/21/2025

How the corrective action will be accomplished for those residents found to be affected by this practice?

- *Audit was started on 10/31/2025 and completed on 11/02/2025 by the Director of Resident Care (DRC) who conducted a comprehensive review of Resident #1's medical record to ensure proper administration of medication and documentation moving forward.*
- *The nursing team was in-serviced on the "Rights of Medication Administration," transcription accuracy, and required actions when medications are ordered but not yet available.*

How the Facility will identify other residents having the potential to be affected by the same deficient practice?

- *All Residents who live in the facility have the Potential to be affected.*

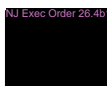
What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur?

- *The Director of resident Care will audit 5 charts a week x4 for oversight of medication administration accuracy and follow-up on missed or delayed doses.*
- *Doctor's order Audit: Director of Resident Care in collaboration with pharmacy representatives have implemented a Weekly order audit to avoid errors or delays in carrying our physicians orders.*

How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?)

- *Audit Results will be reviewed monthly during the Quality Improvement (QI) meeting starting on 12 /21/2025 by the Interdisciplinary Team IDT team.*

Completion Date: 11/29/2025



approved
1/20/26



Carnegie Senior Living
PLAN OF CORRECTION (POC)

A 1289 Annual Survey 11/21/2025

How the corrective action will be accomplished for those residents found to be affected by this practice?

- *The Director of Resident Care (DRC) immediately reviewed Resident #1's medical record, [redacted] consent, and [redacted] history.*
- *Corrective actions for Resident #1 included: Confirmation that a signed consent for **NJ Ex Order 26.4(b)(1)** was present and valid.*

How the Facility will identify other residents having the potential to be affected by the same deficient practice?

- *All Residents who live in the facility have the Potential to be affected.*

What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur?

- *Staff education provided to nursing leadership and admissions staff regarding requirements and facility immunization policy on 11/02/2025 by Regional Nurse.*
- *Upon move in Immediate coordination with the facility's pharmacy and/or medical provider to arrange administration of the consented vaccines.*
- *The Director of Resident Care (DRC) or designee will audit immunization records weekly x4 monthly x3 and quarterly x3 to ensure proper immunization documentation.*

How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?)

- *Audit Results will be reviewed monthly during the Quality Improvement (QI) meeting starting on 12/21/2025 by the Interdisciplinary Team IDT team.*

Completion Date: 11/29/2025

[redacted] NJ Exec Order 26.4b1

approved
1/20/20

Carnegie Senior Living
PLAN OF CORRECTION (POC)

A 1249 Annual Survey 11/21/2025

How the corrective action will be accomplished for those residents found to be affected by this practice?

- *The Director of Maintenance immediately removed the areas of the ceiling that were affected and properly disposed of it. The ceiling was repaired on 10/31/2025.*
- *The Director of Maintenance was in-serviced by the Executive Director on 11/21/2025 on the importance of ensuring the building is in good condition.*

How the Facility will identify other residents having the potential to be affected by the same deficient practice?

- *All Residents who live in the facility have the Potential to be affected.*

What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur?

- *Staff re-education on 11/21/2025 provided to maintenance and leadership staff regarding the importance of prompt reporting and correction of environmental hazards.*
- *The Director of Maintenance or designee will conduct audits as a part of his schedule maintenance rounds of the building to ensure no water damage, weekly x 4, monthly x3 and then quarterly x3.*

How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?)

- *Audit Results will be reviewed monthly during the Quality Improvement (QI) meeting starting on 12/21/2025 by the Interdisciplinary Team IDT team.*

Completion Date: 11/29/2025

NJ Exec Order 26.481



approved
1/20/26

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 90112	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/20/2026
Y1	Y2	Y3
NAME OF FACILITY CARNEGIE ASSISTED LIVING AT PRINCETON		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WINDROW DRIVE 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 A0935	Correction	ID Prefix	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-11.4(b)	Completed	Reg. #	Completed
LSC	11/29/2025	LSC	11/29/2025	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	
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 11/21/2025		<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 90112	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/20/2026
NAME OF FACILITY CARNEGIE ASSISTED LIVING AT PRINCETON		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WINDROW DRIVE 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 A0749	Correction	ID Prefix A0935	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-7.3(a)	Completed	Reg. # 8:36-11.4(b)	Completed
LSC	11/29/2025	LSC	11/29/2025	LSC	11/29/2025
ID Prefix A1289	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-18.2(d)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/29/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY <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 11/21/2025		<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 90112	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/20/2026
NAME OF FACILITY CARNEGIE ASSISTED LIVING AT PRINCETON		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WINDROW DRIVE 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 A1249	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.7	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/29/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 11/21/2025		<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		