New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	90112	A. BUILDING: _____ B. WING _____	C 04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE ASSISTED LIVING AT PRINCETON	1000 WINDROW DRIVE PRINCETON, NJ 08540

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Type of Survey: Complaint Complaint #: NJ 00190471 Census: 72 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administrator's Responsibilities (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/19/26

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A 310	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00190471 Based on interview and record review, it was determined that the Executive Director (ED) failed to ensure that the facility's policies and procedure for monitoring air and water temperatures were comprehensive by identifying or defining the required frequency for temperature monitoring. This deficient practice was evidenced by the following: On 4/24/26, the surveyor reviewed the facility's Policy and Procedure (PP) dated 1/2026 and titled, "Monitoring Air and Water Temperatures" provided by the Executive Director. Surveyor review of the PP revealed that the policy did not identify or define the required frequency for temperature monitoring. The surveyor interviewed the ED and inquired about the frequency of the temperature monitoring. The ED stated that the frequency is determined automatically via the facility's maintenance portal app. Additionally the ED confirmed that the PP that he provided did not identify or define the monitoring frequencies.	A 310		
A 553	8:36-5.7(b) Policy and Procedure Manual (b) The facility shall have a policy and procedure that addresses how policy and procedure manuals will be made available to residents, guardians, designated responsible	A 553		

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A 553	Continued From page 2 individuals, prospective applicants, and referring agencies. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that facility failed to ensure that the facility had a policy and procedure that addressed how the policy and procedure manual (PPM) would be made available to residents, guardians, designated responsible individuals, and referring agencies. This deficient practice was evidenced by the following: On 4/26/26, at 10 a.m., the surveyor interviewed the Executive Director (ED), and requested the facility's PPM from the Executive Director (ED). During the interview, the ED stated that the facility only had an electronic copy of the PPM and would be able to provide any policy and procedure that was requested. The surveyor then requested the policy and procedure that addressed how the PPM would be made available to residents, guardians and/or designated responsible individuals including the policy and procedure pertaining to air temperature monitoring. The ED provided the surveyor the policy on temperature monitoring, however, the ED could not provide the surveyor the policy and procedure addressing how the facility's PPM would be made available to residents, guardians and/or designated responsible individuals.	A 553		

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A1035	Continued From page 3	A1035		
A1035	8:36-14.2(b) Emergency Plans and Procedures (b) The emergency plans, including a written evacuation diagram specific to the unit that includes evacuation procedure, location of fire exits, alarm boxes, and fire extinguishers, and all emergency procedures shall be conspicuously posted throughout the facility. All employees shall be trained in procedures to be followed in the event of a fire and instructed in the use of fire-fighting equipment and resident evacuation as part of their initial orientation and at least annually thereafter. All residents shall be instructed in emergency evacuation procedures. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that emergency plans included a written evacuation diagram that included evacuation procedures, location of fire exits, manual pull stations and fire extinguishers. Additionally, evacuation diagrams specific to the unit were not posted throughout the facility. This deficient practice was evidenced by the following: On 4/24/26 the surveyor reviewed the facility's emergency plans provided by the Executive Director (ED). The evacuation diagram did not include primary and secondary escape routes, the locations of fire exits, manual pull stations or fire extinguishers. At 10:19 a.m., during surveyor tour of the facility	A1035		

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A1035	Continued From page 4 with the Director of Facilities (DOF), the surveyor observed that an evacuation diagram specific to the unit was not posted on floors 1,2 and floor 3. During surveyor interview with the DOF regarding the emergency plan diagram, the DOF acknowledged that the emergency plan's evacuation diagram did not include escape routes, nor the locations of fire exits, manual pull stations or fire extinguishers. The DOF also acknowledged that the evacuation plans specific to the unit were not posted on floors 1,2 and floor 3.	A1035		

POC
Rcd
5/19/26
Accepted
5/19/26

1000 Windrow Drive, Princeton, NJ 08540
(609) 514-9111

CARNEGIE
SENIOR LIVING
AT PRINCETON

Carnegie Senior Living
PLAN OF CORRECTION (POC)

Survey Date: 4/24/2026

A310:

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

- *The Director of Maintenance or designee conducted an immediate air temperature audit on 5/05/2026 of the facility to ensure the building was in compliance.*
- *The facility's policy and procedure titled "Monitoring Air and Water Temperatures" was reviewed on 5/07/26 and revised to include clearly defined monitoring frequencies for both air and water temperature checks. The revised policy outlines the required monitoring intervals, documentation requirements, and staff responsibilities.*
- *The Executive Director educated the maintenance department and applicable staff on 5/7/2026 regarding the revised policy and required monitoring schedule.*

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

All residents have the potential to be affected by the facilities failure to ensure the policies and procedure for Air and Water Temperature Monitoring identified frequency.

What measures will be put into place or systemic changes made to ensure the deficient practice will not recur:

The facility implemented the following systemic changes:

- *The Executive Director revised the "Monitoring Air and Water Temperatures" policy to include defined monitoring frequencies.*
- *The Director of Maintenance or designee will conduct temperature monitoring in accordance with the facility policy.*

- *The Executive Director educated maintenance staff on 5/7/2026 on the revised policy and documentation expectations.*
- *The Executive Director or designee will conduct routine audits of the temperature logs and maintenance portal documentation to ensure ongoing compliance weekly x 4 weeks, monthly x 3 months and quarterly thereafter.*

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

The Executive Director or designee will bring findings of these audits to the monthly Managers meetings to determine the future frequency of these audits. Any identified concerns will be addressed immediately through additional education and corrective action as necessary.

Completion date: 5/7/2026

accepted 5/19/26

A553:

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

- *The facility reviewed their policy and procedure titled "Availability of Policy and Procedure Manual." The policy outlines the process for making the facility's policy and procedure manual accessible to residents, guardians, designated responsible individuals, prospective applicants, and referring agencies upon request.*

- *The receptionists were re-educated on 5/7/2026 - 5/08/2026 regarding the process for providing access to the policy and procedure manual to residents and family members upon request.*

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

All residents have the potential to be affected by the facilities failure to ensure that there was a policy and procedure addressing how the facility's policy and procedure manual would be made available to residents, guardians, designated responsible individuals, prospective applicants, and referring agencies.

What measures will be put into place or systemic changes made to ensure the deficient practice will not recur:

- *The Executive Director updated the policy and procedure addressing accessibility of the facility's policy and procedure manual on 5/7/2026.*

- *The Executive Director re-educated all administrative staff on 5/7/2026 on the process to provide copies of policies upon request.*

- *The Executive Director or designee will audit requests monthly for 3 months, and quarterly thereafter to ensure that requests are following the policy and procedure.*

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

The Executive Director or designee will bring the findings of these audits monthly to the Managers meetings to determine the future frequency of these audits. Any identified concerns will be addressed promptly through re-education and corrective action.

Completion date: 5/8/2026

accepted 5/9/26 [redacted]

A1035:

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

- *The facility revised the emergency evacuation diagrams on 5/7/2026 to include primary and secondary evacuation routes, locations of fire exits, manual pull stations, and fire extinguishers.*

- *Updated evacuation diagrams specific to each unit were posted throughout floors 1, 2, and 3 in conspicuous locations accessible to residents, staff, and*

visitors.

- *The Director of Facilities educated the Executive Director and applicable staff on 5/7/2026 regarding the requirements for maintaining accurate and properly posted evacuation diagrams throughout the facility.*

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

All residents, have the potential to be affected by the facility failing to ensure evacuation diagrams included evacuation procedures, primary and secondary escape routes, locations of fire exits, manual pull stations, and fire extinguishers

What measures will be put into place or systemic changes made to ensure the deficient practice will not recur:

- *The Executive Director revised all emergency evacuation diagrams on 5/7/2026 to include required emergency information including primary and secondary evacuation routes, fire exits, manual pull stations, and fire extinguishers; and ensured these diagrams were posted in proper locations.*

- *The Director of Facilities educated the Executive Director and applicable staff on 5/7/2026 regarding the requirements for maintaining accurate and properly posted evacuation diagrams throughout the facility.*

- *The Director of Maintenance will audit the facility to ensure evacuation diagrams are in compliance monthly x 3 months and quarterly thereafter.*

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

The Director of Maintenance or designee will bring the findings of the above audits to the Monthly Managers meeting to determine the future frequency of these audits. Any identified concerns will be corrected immediately and additional staff education will be provided as needed.

Completion Date: 5/07/2026

accepted 5/1

[redacted] NJ Ex Order 26.4(b)(1)

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
90112 Y1	A. Building B. Wing Y2	4/24/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE ASSISTED LIVING AT PRINCETON	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 A0553	Correction	ID Prefix A1035	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-5.7(b)	Completed	Reg. # 8:36-14.2(b)	Completed
LSC	05/07/2026	LSC	05/08/2026	LSC	05/07/2026
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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/24/2026	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO