

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>12A040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/16/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MAPLEWOOD AT PRINCETON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1 HOSPITAL DRIVE PLAINSBORO, NJ 08536</b>
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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: REVISED TYPE OF SURVEY: Initial Survey of newly established 130 Assisted Living bed facility (revised from 105 AL beds to 130), 26 of which are dedicated Memory Care Unit beds. The facility has a total of 105 residential units/apartments.</p> <p>CENSUS: 0</p> <p>SAMPLE SIZE: 0</p> <p>The facility was in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs, based on this Complaint survey.</p>	A 000		

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

TITLE

(X6) DATE