STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315370	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETON LLC	**5000 WINDROW DRIVE , PRINCETON, New Jersey, 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) COMPLETION DATE
F0000	INITIAL COMMENTS Federal Initial Comments (FOO) COMPLAINT #: 2624594, 2593784, 2584559 CENSUS: 154 SAMPLE SIZE: 5 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. The NJDOH conducted a Complaint survey on 10/17/25. The survey was officially completed on 10/17/25.	F0000		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Complaint # 2624594, 2593784, 2584559 Based on interviews, medical record review, and review of pertinent facility documents on 10/17/25, it was	F0686	How the corrective action be accomplished for those residents found to be affected by this practice? Affecting resident #5. Upon identification, [redacted] care treatment was initiated immediately in accordance with [redacted] consultant and physician recommendations. The attending physician and [redacted] consultant were notified, and orders were reviewed and clarified as needed. Resident #5 no longer in the facility On 10/17/25 Licensed nursing staff received immediate education on immediate initiation of [redacted] care treatment as recommended in accordance with professional standards of practice How the Facility will identify other residents having the potential to be affected by the same deficient practice? All Residents have the ability to be affected by the facility not meeting the requirements of ensuring immediate initiation of wound care treatment as	01/19/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315370	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

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F0686 SS = D	Continued from page 1 determined that the facility failed to initiate a [NJ Exec Orde] care treatment as recommended for three days in accordance with professional standards of practice. This deficient practice was identified for 1 of 5 residents reviewed for [NJ Exec Order] (Resident #5). The evidence was as follows: A review of the Admission Record (AR) revealed that Resident #5 was admitted to facility with diagnoses that included but were not limited to, [NJ Exec Or] [redacted] A review Resident #5's comprehensive Minimum Data Set (MDS) dated [NJ Exec Orde] revealed that the resident had a Brief Interview Mental Status (BIMS) score of [NJ E] out of 15, indicating that the resident's [NJ Exec Order 26] was NJ Exec Order 26.4b1. A review of Resident #5's Care Plan (CP) with a focus initiated on [NJ Exec Ord], revealed that the resident had a potential for [NJ Exec Order 26.4b1]. intervention, the care plan identified a 'NJ Exec Order 26.4b1, [NJ Exec Orde] at NJ Exec Order 26.4b1 [redacted]." the care plan further revealed "[NJ Exec Orde] care per physician orders" A review of a document titled "multi [NJ Exec Orde] chart details" dated [NJ Exec Order 2] indicated the following physician's recommendations as follows: '[NJ Exec Orde] #1" [NJ Exec Order] the [NJ Exec Order 2] with NJ Exec Order 26.4b1 [redacted] Secondary [NJ Exec Order 2] revealed recommendations as follows: 1. [NJ Exec Order 26.4b1] included [NJ Exec Order 26.4b1], and that "this treatment will be done daily and as needed until discontinued. Today's treatment will be performed by the [NJ Exec Orde] care team and other care performed by the staff of the facility." A review of the "Order Summary Report" (ASR) titled "Active Orders As Of [NJ Exec Order 26.4b] included a physician order dated [NJ Exec Order 2] for Resident #5's [NJ Exec] to [NJ Exec Order] [redacted]	F0686	Continued from page 1 recommended in accordance with professional standards of practice What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? On 10/17/25 Licensed nursing staff received immediate education on immediate initiation of wound care treatment as recommended in accordance with professional standards of practice Effective 10/17/25 The facility conducted an audit of all residents with pressure injuries or other wounds to ensure immediate initiation of wound care treatment as recommended in accordance with professional standards of practice A standardized wound care order verification and initiation process was implemented in accordance with facility policy. 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?) DON/ADON or designee will conduct random weekly wound audits 5 residents for four (4) weeks, followed by monthly audits for three (3) months to ensure immediate initiation of wound care treatment as recommended in accordance with professional standards of practice DON/ADON or designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315370	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

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F0686 SS = D	Continued from page 2 NJ Exec Order 26.4b1 and NJ Exec O with NJ Exec Order 26.4b1 daily and as needed. On 10/17/25 at 3:33PM, the surveyor interviewed the US FOIA (b)(6) who stated that the date on the "Physician Recommendation Details" report was written on the day the NJ Exec Orde care team was in the facility to evaluate the NJ Exec Orde The US FOIA stated that the facility waited until they received the official report on NJ Exec Order before they added the newly recommended NJ Exec Orde treatment orders. The US FOIA stated that even though the treatment was recommended on NJ Exec Order, facility had to wait till the NJ Exec Orde sent their new recommendation to NJ Exec Orde Resident # 5's NJ Ex treatment. The US FOIA stated that the new NJ Exec Orde treatment orders was implemented on NJ Exec Order 2 and that facility did not consider the 2 -day waiting period a delay in treatment. A review of the facility's policy titled "Wound Care" with a reviewed date of 12/2024 revealed under Procedure #10. "Follow treatment as ordered". The facility did not follow the treatment as ordered from NJ Exec Order 26.4b1 NJAC 8:39-27.3(i)	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 62202	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETON LLC	**5000 WINDROW DRIVE , PRINCETON, New Jersey, 08540**

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S0000	Initial Comments SURVEY DATE: 10/17/2025 COMPLAINT #: 2584559, 2593784, 2624594 CENSUS: 154 SAMPLE SIZE: 5 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. 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 the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S0000		
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint #: 2584559, 2593784, 2624594 Based on review of facility documents on 10/17/2025, it was determined that the facility failed to ensure staffing ratios were met for 8 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S0560	How will the corrective action be accomplished for those residents found to be affected by this practice? On 12/17/25 The staffing coordinator was educated on the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. The facility will continue to reach out to existing staff to see if they want to pick up overtime shifts and continue to try and staff accordingly How the Facility will identify other residents having the potential to be affected by the same deficient practice? All residents have the ability to be affected by the facility failing to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey.	01/19/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 62202	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

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S0560	Continued from page 1 codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing prior to survey from 09/28/2025 to 10/11/2025, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows: On 09/28/25, the facility had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. On 09/29/25, the facility had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. On 10/01/25, the facility had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. On 10/05/2025, the facility had 17 CNAs for 150 residents on the day shift, required at least 19 CNAs. On 10/06/2025, the facility had 18 CNAs for 150 residents on the day shift, required at least 19 CNAs. On 10/08/2025, the facility had 16 CNAs for 147 residents on the day shift, required at least 18 CNAs. On 10/09/2025, the facility had 17 CNAs for 147 residents on the day shift, required at least 18 CNAs. On 10/11/2025, the facility had 18 CNAs for 151 residents on the day shift, required at least 19 CNAs.	S0560	Continued from page 1 What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? Effective 12/17/25 .The facility posted job openings on job sites to promote CNA openings Effective 12/17/25 The facility is offering a sign on bonus Effective 12/17/25The facility has contracted with multiple agencies to assist with our staffing needs 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 administrator/designee will review one days staffing sheets weekly x 4 then monthly for 3 months and quarterly thereafter. The Administrator/designee will review any findings of these audits and present them quarterly x 4 with the Quality Assurance Performance Improvement committee to determine frequency of future audits.	

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 1/21/2026 in relation to the 10/17/2025 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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New Jersey State Department of Health

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 1/21/2026 in relation to the 10/17/2025 State of New Jersey Complaint survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities.	S0000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE