STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315370	A. BUILDING _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETON LLC	**5000 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) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 2/14/25 to 2/25/25 Census: 156 Sample: 31+ 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions.	F 636		4/10/25

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

Electronically Signed | 03/13/2025

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 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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F 636	Continued From page 1 (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to complete the Admission Minimum Data Set	F 636	How will the corrective action be accomplished for those residents found to be affected by this practice? ¿ Affecting resident #339 The	

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F 636	Continued From page 2 (MDS), a periodic and federally mandated, standardized assessment tool, within the required time frame. This deficient practice was identified for 1 of 2 residents (Residents #339) reviewed for timing of assessments and was evidenced by the following: This deficient practice was evidenced by the following: On 2/21/25 a review of the electronic health record (EHR) reflected that Resident #339 was admitted to the facility on [NJ Exec Order 26.4b1]. The Comprehensive Admission MDS was noted to be "in progress." On 2/21/25 at 12:45 PM, the surveyor interviewed the [US FOIA (b)(6)], who stated the MDS assessment on a new admission was due within 14 days of admission. She further stated that she was working on this MDS now and that it should've been done the day before yesterday [NJ Exec Order 26.4b1] A review of facility provided "MDS Policy" reviewed 10/2024 included: Policy: It is the policy and procedure of this facility to follow the latest version of the Resident Assessment Manual and CMS (Centers For Medicare and Medicaid) regulations and requirements. Purpose: 1. To outline the procedure of identifying and addressing residents' strengths and needs through the RAI (Resident Assessment Instrument) process 2. To provide information on the resident's	F 636	Comprehensive Assessment has been completed. ¿ The [US FOIA (b)(6)] was in-serviced on Comprehensive Assessment timing, completing the Admission Minimum Data set within 14 calendar days after admission. 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 ensure that the Admission Minimum Data set was completed within the required timeframe. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ A second Minimum Data Set Nurse will assist the Minimum Data Set Coordinator in completing the admission assessments when outstanding assessments remain, prior to the end of the required timeframe. ¿ The Minimum Data Set Coordinator/designee will audit 5 Resident□s Minimum Data Set to ensure the admission assessments were completed within the required timeframe, weekly for a month, monthly for 3 months, and quarterly thereafter. 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 Minimum Data Set Coordinator/designee will review any	

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F 636	Continued From page 3 condition 3. To facilitate development of a comprehensive care plan. 4. To ensure care delivery that enhances the resident's quality of life. 5. To help achieve the highest and practical level of self sufficiency. Procedure: MDS Department 1. Schedules Minimum Data Set (MDS) and Care Plan Meeting in accordance to existing regulations governing RAI process. 3. Assures the completeness and accuracy of the information in the MDS. 5. Coordinates, signs and certifies the completion of the MDS. 6. Submits MDS data in required format to CMS. 8. Reviews and corrects errors with the MDS Coordinator. According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated October 2024, page 2-17, the Comprehensive Admission assessment must be completed no later than the admission date + 13 calendar days.	F 636	findings of these audits and present them quarterly x 3 with the Quality Assurance Performance Improvement committee to determine frequency of future audits.	
F 640 SS=D	NJAC 8:39-11.2 (e) Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for	F 640		4/10/25

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F 640	Continued From page 4 each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must	F 640		

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F 640	Continued From page 5 transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview, review of medical records and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to complete and electronically transmit the Minimum Data Set (MDS), an assessment tool, within 14 days of the resident's discharge. This deficient practice was identified for 1 of 1 resident, (Resident # 83) reviewed in the Resident Assessment Task for MDS record over 120 days old. On 2/18/25, the surveyor reviewed the MDS history in the electronic medical record (EMR), which revealed that Resident #83 was discharged on [redacted]. The surveyor was unable to locate a discharge MDS in Resident #83's EMR. On 2/18/25, the surveyor interviewed the [redacted], who stated the discharge MDS on Resident #83 should've been completed within 14 days of the discharge date. She also stated, "I'm not sure what happened." On 2/25/25, after surveyor inquiry, the surveyor noted the discharge MDS was completed on [redacted] and was transmitted on [redacted] (completion was due by [redacted] and transmission was due by [redacted]).	F 640	How will the corrective action be accomplished for those residents found to be affected by this practice? Affecting resident #83 the minimum data set has been completed and transmitted. The [redacted] was in-serviced on completing, and electronically transmitting the minimum data set for discharged residents within the required timeframe. 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 complete and electronically transmit the minimum data set, within 14 days of a resident□s discharge. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? A second Minimum Data set Nurse will assist the Minimum Data Set Coordinator in completing and transmitting the minimum data set of discharged residents when outstanding assessments remain prior to the end of the compliance period. The Minimum Data Set Coordinator will audit the electronic medical records of 5 residents that were discharged from the facility to ensure that the minimum data set was completed and electronically	

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F 640	Continued From page 6 A review of facility provided "MDS Policy" reviewed 10/2024 revealed: Policy: It is the policy and procedure of this facility to follow the latest version of the Resident Assessment Manual and CMS regulations and requirements. Purpose: 2. To provide information on the resident's condition Procedure: MDS Department 1. Schedules Minimum Data Set (MDS) and Care Plan Meeting in accordance to existing regulations governing RAI (Resident Assessment Instrument) process. 3. Assures the completeness and accuracy of the information in the MDS. 5. Coordinates, signs and certifies the completion of the MDS. 6. Submits MDS data in required format to CMS (Centers for Medicare and Medicaid Services). According to Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 user's manual dated October 2024, page 2-19, the discharge return-not anticipated assessment must be completed no later than the discharge date + 14 calendar days with the transmission date no later than MDS completion date +14 days. NJAC 8:39-11.2 (e) 3	F 640	transmitted within the required timeframe weekly for a month, monthly for 3 months, and quarterly thereafter 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 Minimum Data Set Coordinator/designee will review any findings of these audits and present them quarterly with the Quality Assurance and Performance Improvement committee to determine frequency of future audits.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		4/10/25

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F 641	Continued From page 7 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00179151 Based on observation, interview, review of medical records, other facility documentation, and review of the Resident Assessment Instrument (RAI) User's Manual, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool, for 3 of 31 residents reviewed (Resident #5, Resident #43, and Resident #53) for MDS accuracy. This deficient practice was evidenced by the following: 1. On 2/19/25 at 11:33 AM, the surveyor observed Resident #5, in a wheelchair, in the day room on the [redacted] floor. The resident was noted with their [redacted]. On 2/19/25 at 02:43 PM, the surveyor observed Resident #5, out of bed, in a wheelchair in the bedroom, [redacted]. On 02/19/25 at 02:46 PM, the surveyor observed Resident #5, in a wheelchair in the [redacted] floor dining room [redacted]. A review of Resident #5's admission record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; [redacted]). A review of the Medication Administration Record	F 641	How will the corrective action be accomplished for those residents found to be affected by this practice? Affecting residents #5 #43 and #53 the minimum data set coding has been modified. The [redacted] was in-serviced on accuracy of assessments related to coding behavior symptoms exhibited, tobacco use, and activities of daily living status. 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 accurately complete the minimum data set . What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The Certified Nursing Assistants were in-serviced on proper documentation on activities of daily living status. The [redacted] was in-serviced on reviewing the entire residents□ chart including but not limited to care plans, tasks, and progress notes in order to accurately complete the Minimum Data Set. The Minimum Data Set Coordinator will audit 10 resident□s minimum data set to ensure accuracy of coding weekly for 1	

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F 641	Continued From page 8 (MAR) for NJ Exec Order 26.4b1 revealed documentation under NJ Exec Order 26.4b1 that indicated that NJ Exec Order 26.4b1 occured multiple times daily on all shifts during the look back period of NJ Exec Order 26.4b1 except for NJ Exec Order 26.4b. A review of the comprehensive significant change MDS, dated NJ Exec Order 26.4, revealed the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15 indicating NJ Exec Order 26.4b1 Further review revealed, Section NJ E of the MDS, question NJ Exec Order 26.4 was coded NJ E indicating NJ Exec Order 26.4b1 exhibited during the look back period of 7 days. On 2/21/25 at 10:44 AM, the surveyor interviewed the US FOIA (b)(6) , who when asked about the NJ Exec Order 26.4b coding, stated Resident #5 was NJ Exec during the lookback period. After reviewing the MAR, she stated she was going to modify the MDS to correct it. 2. On 2/14/25 at 10:49 AM, the surveyor observed Resident #43 in bed. The resident verbalized current NJ Exec Order 26.4b status and stated that the facility holds the NJ Exec Order 26.4b1 and NJ Exec Order 26 On 2/18/25 at 2:00 PM, the surveyor observed Resident #43 in a wheelchair, getting onto the elevator on NJ Exec floor. The resident stated they were going out to NJ Exec Order 26 after getting NJ Exec Order 26.4b1 and NJ Exec Order from the receptionist. A review of Resident #43's admission record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; orthopedic aftercare following NJ Exec Order 26.4	F 641	month, monthly for 3 months, and quarterly thereafter. 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 Minimum Data Set Coordinator/designee will review any findings of these audits and present them quarterly with the Quality Assurance and Performance Improvement committee to determine frequency of future audits.	

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F 641	Continued From page 9 NJ Exec Order 26.4b1 [redacted]) A review of the individual comprehensive care plan (ICCP) revealed a focus area of NJ Ex Order 26.4b1 [redacted] dated NJ Exec Order 26.4b1 with interventions including resident will follow the NJ Exec Order 26.4b policy, resident will be free of NJ Exec Order associated with NJ Exec Order 26.4b1 complete NJ Exec Order 26.4b assessment upon admission, quarterly and as needed, and education to be provided to the resident regarding health complications related to NJ Exec Order 26.4b1 A review of NJ Exec Order 26.4b evaluations completed NJ Exec Order 26.4b1 [redacted] all indicate Resident #43 was safe to NJ Exec Order 26 [redacted] A review of the annual comprehensive MDS dated NJ Exec Order 26.4b revealed the resident had a BIMS score of NJ Ex [redacted] out of 15, indicating NJ Exec Order 26.4b1 Further review revealed Section NJ E [redacted] question NJ Exec Order 26 [redacted] was coded NJ E [redacted] indicating no current NJ Exec Order 26.4b use. On 2/21/25 at 10:44 AM, the surveyor interviewed the US FOIA (b)(6) , who stated that Resident #43 was a NJ Exec Order 26.4b [redacted] the NJ Exec Order 26.4b assessment was overlooked when the MDS was completed. She further stated that she modified the MDS to correct it. 3. On 2/14/25 at 11:26 AM, the surveyor observed Resident #53 in bed. The resident stated, 'NJ Exec Order 26.4b1." The call bell was noted to be on and was answered by a certified nurse assistant (CNA) in about 3 minutes. On 2/18/25 at 01:06 PM, the surveyor observed	F 641		

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F 641	Continued From page 10 Resident #53 in a wheelchair in the hallway. The resident stated they had [redacted] today and it was [redacted]. The resident was [redacted] and appeared [redacted] and [redacted]. On 2/19/25 at 9:47 AM, the surveyor observed Resident #53 lying in bed. The resident stated they were [redacted] and further stated that the staff helps them when needed within a reasonable time. On 2/20/25 at 9:44 AM, the surveyor observed Resident #53 lying in bed with their [redacted]. A review of Resident #53's admission record reflected the resident had diagnoses that included but were not limited to; [redacted]). A review of the IDCP (interdisciplinary care plan) summary dated [redacted], reflected the resident required [redacted] assistance with [redacted] and [redacted] and [redacted] or [redacted] with [redacted]. A review of the ICCP revealed a focus area of ADL (activities of daily living) self care performance deficit related to [redacted] and [redacted]) dated [redacted]. Interventions included praise all efforts at self care, encourage participation to the fullest extent possible with each interaction, and encourage to use call bell for assistance. The ICCP also included a focus area of [redacted] related to the [redacted] process dated [redacted]	F 641		

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F 641	Continued From page 11 which included interventions of staff to check frequently for NJ Exec Order 26.4b1 and for staff to wash, rinse, and NJ Exec Order 26.4b1 A review of the quarterly MDS dated NJ Exec Order 26.4, revealed the resident had a BIMS of NJ Exe out of 15, indicating NJ Exec Order 26.4b1. Further review revealed Section NJ Exec O questions NJ Exec Order 26.4b1 NJ Exec Order 26.4b NJ Exec Order 26.4b1 all coded as NJ Exec Order 26.4b1 On 2/21/25 at 10:44 AM, the surveyor interviewed the US FOIA (b)(6) , who stated section NJ Exec O is a little different, and that when she interviewed the CNA and the staff, they indicated the resident was NJ Exec Order 26.4b1 When surveyor showed her the IDCP Summary dated NJ Exec Order 26 and the task sheet for NJ Exec Order 26.4b1 which had many codes of NJ E indicating NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 and a few codes of NJ E indicating NJ Exec Order O or NJ Exec Order 26.4b1 assistance needed during the 7 day look back period, she stated that she had seen that, but her interviews said the resident was NJ Exec Order 26.4b1 Review of "MDS Policy" Reviewed 10/2024 included: Policy: It is the policy and procedure of this facility to follow the latest version of the Resident Assessment Manual and CMS (Center for Medicare and Medicaid) regulations and requirements. Purpose: 1. To outline the procedure of identifying and addressing residents' strengths and needs through the RAI (Resident Assessment Instrument) process 2. To provide information on the resident's condition	F 641		

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CARNEGIE POST ACUTE CARE AT PRINCETON LLC	**5000 WINDROW DRIVE PRINCETON, NJ 08540**

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F 641	Continued From page 12 3. To facilitate development of a comprehensive care plan. 4. To ensure care delivery that enhances the resident's quality of life. 5. To help achieve the highest and practical level of self sufficiency. Procedure: MDS Department 1. Schedules Minimum Data Set (MDS) and Care Plan Meeting in accordance to existing regulations governing RAI process. 3. Assures the completeness and accuracy of the information in the MDS. 5. Coordinates, signs and certifies the completion of the MDS. 6. Submits MDS data in required format to CMS. 8. Reviews and corrects errors with the MDS Coordinator.	F 641		
F 712 SS=D	N.J.A.C 8:39-11.1 Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.	F 712		4/10/25

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F 712	Continued From page 13 §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00179151 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to ensure that the responsible physician supervising the care of residents conducted face-to-face visits and wrote progress notes at least once every thirty days from [redacted] for 1 of 34 residents, (Resident #5) reviewed for physician visits. This deficient practice was evidenced by the following: On 2/19/25 at 11:33 AM, the surveyor observed Resident #5 in a wheelchair in the day room on the [redacted] floor. The resident was noted with their [redacted] and [redacted]. A review of Resident #5's admission record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; [redacted] A review of the comprehensive significant change Minimum Data Set (MDS), an assessment tool dated [redacted], revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating [redacted].	F 712	How will the corrective action be accomplished for those residents found to be affected by this practice? ¿ The Director of Nursing sent out notifications to all attending Physicians reminding them of their required visits and documentation. ¿ Affecting resident #5 The physician conducted a face-to-face visit and documented in the residents chart. ¿ [redacted] was in-serviced on the frequency of physician visits and required documentation requirements 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 ensure that the responsible physician supervising the care of residents conducts face-to-face visits and writes progress notes at least once every 30 days. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The Unit Manager/designee will notify the Physicians if a visit and progress note has not been conducted and written per Centers for medicare and medicaid	

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F 712	Continued From page 14 A review of the electronic medical record (EMR) revealed a progress note from Resident #5's attending physician on [NJ Exec Order 26.4] No further attending physician notes were found in the EMR by the surveyor. On 2/25/25 at 02:08 PM, the [US FOIA (b)(6)] provided physician visits for Resident #5 handwritten on paper dated [NJ Exec Order 26.4b1]. When the [US FOIA (b)] was asked if this was all the visits, he stated yes. When asked what the requirement was, he stated the regulation is every 30 days for long term care. On 2/25/25 at 02:22 PM, the [US FOIA (b)(6)] provided additional physician visits for Resident #5 handwritten on paper dated [NJ Exec Order 26.4b1] Addition review of the EMR and handwritten physician notes did not reveal a progress note from the attending physician for [NJ Exec Order 26.4b1] A review of facility provided policy "Physician visits" included: Policy: It is the policy and procedure of this facility that the Attending Physician must make visits in accordance with applicable state and federal regulations. Procedure: 1. The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admissions, and then at least every sixty (60) days thereafter.	F 712	services guidelines. ¿ The Unit Manager/designee will audit 10 Residents□ charts for compliance of frequency of physician visits and documentation monthly for 3 months, and quarterly thereafter. 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 Unit Manager/designee will review any findings of these audits and present them quarterly with the Quality Assurance and Performance Improvement committee to determine frequency of future audits.	

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F 712	Continued From page 15 NJAC 8:39-23.2 (d) reveals: "A physician or advanced practice nurse shall visit each resident at least every 30 days unless the medical record contains an explicit justification for not doing so. Following the initial visit, alternate 30-day visits may be delegated by a physician to a New Jersey licensed physician assistant, in accordance with facility policies."	F 712		
F 758 SS=D	N.J.A.C, 8:39-23.2 (d) Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		4/10/25

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F 758	Continued From page 16 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00179151 Based on observations, interviews, review of the medical record and review of other facility documentation, it was determined that the facility failed to ensure adequate indication for a resident with [redacted] prior to the administration of an [redacted] medication ([redacted] This deficient practice was identified for 1 of 6 residents (Resident #5) reviewed for unnecessary medications and was evidenced by the following: On 2/14/25 at 12:13 PM, the surveyor observed Resident #5 in a wheelchair with [redacted] in the [redacted] floor dining room ready for lunch.	F 758	How will the corrective action be accomplished for those residents found to be affected by this practice? ¿ Affecting resident #5 A [redacted] has been initiated. ¿ The [redacted] were in-serviced on approved diagnosis required prior to the administration for [redacted] medications. How will the Facility 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 ensure that an adequate indication is present for	

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F 758	Continued From page 17 On 2/19/25 at 9:55 AM, the surveyor observed Resident #5 in a wheelchair in the day room on the [redacted] floor. The resident was sitting with their [redacted] and [redacted]. On 2/19/25 at 10:28 AM, the surveyor observed Resident #5 in a wheelchair in the day room on the [redacted] floor. The resident was sitting with their [redacted] and [redacted]. On 2/19/25 at 11:33 AM, the surveyor observed Resident #5 in a wheelchair in the day room on the [redacted] floor. The resident was sitting with their [redacted] and [redacted]. On 2/19/25 at 12:28 PM, the surveyor interviewed the[redacted] who stated regarding Resident #5 and the [redacted] of [redacted] that "they (the resident) are[redacted]. They used to [redacted] to get out of [redacted] We have really [redacted] them to be out of [redacted] We encourage activities. If the [redacted] floor can't keep them occupied, then they go to the [redacted] floor. The team has spent much time on this and this is a [redacted]. This resident is definitely a "[redacted] "I don't have a very good answer." He further stated the team has put a lot of thought into this, it comes up in meetings all the time. On 2/19/25 at 02:43 PM, the surveyor observed Resident #5 in a wheelchair in the bedroom, [redacted]. On 02/19/25 at 02:46 PM, the surveyor observed Resident #5 in a wheelchair in [redacted] floor dining room [redacted]	F 758	a resident with behaviors prior to the administration of an antipsychotic medication. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The [redacted] were in-serviced on approved diagnosis required prior to the administration for antipsychotic medications. ¿ The Unit Manager/designee will review consultations related to psychotropic medications to ensure that there is adequate indication prior to the administration of antipsychotic medication. ¿ The Unit Manager/designee will audit the clinical records of 5 residents who are receiving antipsychotic medication weekly for 1 month, monthly for 3 months, and quarterly thereafter to ensure that an approved diagnosis is documented. How will the Facility 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 Unit Manager/designer will review any findings of these audits and present them quarterly with the Quality Assurance and Performance Improvement committee to determine frequency of future audits.	

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F 758	Continued From page 18 On 2/20/25 at 9:39 AM, the surveyor observed Resident #5 in the [redacted] floor day room, [redacted] in a wheelchair, an [redacted]" trivia was going on in the activity room. On 2/20/25 at 12:19 PM, the surveyor observed Resident #5 in [redacted] floor dayroom, [redacted] in a wheelchair. A review of Resident #5's admission record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; [redacted]). A review of the physician's orders revealed an order for [redacted] at bedtime for [redacted] dated [redacted] An additional order, dated [redacted] was noted for [redacted] at bedtime for [redacted] A review of the [redacted] progress note dated [redacted], revealed a recommendation for [redacted] for [redacted]. The following was also recommended on [redacted] "Always consider [redacted] and individualized [redacted] interventions, inc: [redacted], [redacted], [redacted], [redacted], [redacted]. Treat medical issues including [redacted], [redacted] Encourage participation in activities, [redacted] as [redacted] and as possible for [redacted]." A review of the Medication Administration Record	F 758		

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F 758	Continued From page 19	F 758		

(MAR) for NJ Exec Order 26.4b1 revealed documentation under NJ Exec Order 26.4b1 multiple times daily and throughout all shifts.

A review of the comprehensive significant change Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b revealed the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, indicating NJ Exec Order 26.4b1. A further review revealed Section NJ E indicated the use of an NJ Exec Order 26.4b1 and an appropriate indication for the use.

A review of the individual comprehensive care plan (ICCP) revealed focus areas of use of NJ Exec Order medication for diagnosis of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b problem of NJ Exec Order 26.4b1 and NJ Exec Order with interventions including to inform resident and family members of indication for medication and side effects, administer medications as ordered, intervene as necessary to protect the rights and safety of others, and to offer NJ Exec Order 26.4b1.

Further review of the medical records did not reveal a diagnosis of NJ Exec Order 26.4b1

On 2/25/25 at 10:30 AM, the surveyor spoke with the certified US FOIA (b)(6) who stated that in NJ Exec Order 26.4b she had noted to clarify diagnosis for the use of NJ Exec Order 26.4b1 as NJ Exec Order 26.4b1 is not an approved diagnosis for NJ Exec Order 26.4b1

Review of facility provided policy "1.0 Psychotropic Drug Use", revised 10/1/24 which included:
Policy:
When clinically appropriate, the facility staff will initiate non-medication approaches to care to

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F 758	Continued From page 20 assist in the treatment of alteration of the customer's behavior as behavioral redirection, environmental alterations, etc. Procedure: A. Each customer receiving an antipsychotic medication for organic mental disorders (now referred to as dementia, Alzheimer's disease, or other cognitive disorders by DSM-IV) is observed for: 1. Episodes of the behavioral symptoms being treated and/or manifestations of the disordered thought process. 2. Adverse reactions and side effects 3. Appropriateness of drug selection and dosage C. Antipsychotics are not to be used if one (1) or more of the following is/are the only indication: 5. Anxiety 6. Depression w/o psychotic features 13. Agitated behaviors which do not represent a danger to the customer or others F. Each customer on an antipsychotic for organic mental syndrome with agitation or psychosis has a plan of action the includes dosage reduction and behavioral interventions unless clinically contraindicated as defined below. I. When psychotropic drugs are used outside the recommended dosage ranges of the federal interpretive guidelines, the physician or nursing staff (per physician explanation) documents the reason (i.e. maintenance or improvement of customer's functional status) for the higher dose and the absence of adverse drug reactions (ADRs). On 2/25/25 at 9:35 AM, the survey team met with the US FOIA (b)(6) and the US FOIA (b)(6)	F 758		

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F 758	Continued From page 21 US FOIA (b)(6)). The US FOIA (b)(6) stated that the US FOIA (b)(6) started the resident on the NJ Ex Order 26.4b1 not us (the facility). Reference: A review of the manufacturer's specifications for Seroquel (quetiapine) under the black box warning reflected "Warning: Increased Mortality In Elderly Patient with dementia related psychosis and suicidal thoughts and behaviors." Section 1 Indications and Usage included schizophrenia, bipolar disorder, and special considerations in treating pediatric schizophrenia and bipolar 1 disorder. Section 5.1 included, Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death ... Section 5.3 Cerebrovascular Adverse Reactions, Including Stroke, in Elderly Patients with Dementia-Related Psychosis ... Cerebrovascular Adverse Reactions, Including Stroke, in Elderly Patients with Dementia-Related Psychosis.	F 758		
F 868 SS=D	N.J.A.C. 8:39-27.1 (a) QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 868		4/10/25

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F 868	Continued From page 22 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, the facility failed to a.) ensure the required committee members, the US FOIA (b)(6) was present for one of seven Quality Assurance and Performance Improvement (QAPI) meetings and b.) review of Antibiotic Stewardship (AS). This deficient practice was evidenced by the	F 868	How will the corrective action be accomplished for those residents found to be affected by this practice? ¿ Affecting all residents the US FOIA (b)(6) were in-serviced that the facility is required to have an Infection preventionist present at the Quality Assurance and Improvement Meeting.	

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F 868	Continued From page 23 following: A review of the facility provided "QAPI Meeting 3rd Quarter" dated 10/17/24, did not reveal the US FOIA (b)(6) signed in. A review of the facility provided "QAPI Meeting 4rd Quarter" dated 1/16/24, revealed the US FOIA (b)(6) signed in. On 02/25/25 at 1:21 PM, the surveyor met with the US FOIA (b)(6) to review the facility's QAPI. The US FOIA (b)(6) reviewed the QAPI sign in sheets dated 10/17/24 and verified he did not see where the IP had signed in. The surveyor asked the US FOIA (b)(6) to show the AS Information that was reviewed with the committee. The US FOIA (b)(6) reviewed the QAPI binder and was unable to locate the AS data, he acknowledged that the other departments information was in the binder. During that meeting, the US FOIA (b)(6) verified the US FOIA (b)(6) attended the 1/16/25 meeting, but the US FOIA (b)(6) was unable to show the AS information that was reviewed. He stated that usually the AS was printed and reviewed at the meeting. He then added that the information could be pulled from the electronic medical record system for tracking. The surveyor made the US FOIA (b)(6) aware of the AS binders tracking from July 2024 to present were printedon 2/17/25 by the US FOIA (b)(6). A review of the facility's policy, "Antibiotic Stewardship" reviewed 9/3/24 revealed. Policy: It is the policy of Carnegie Post Acute Care to implement an Antibiotic Stewardship program (ASP) which will promote appropriate use of	F 868	¿ Affecting all residents the Administrator and the Director of Nursing were in-serviced on the facility's policy on antibiotic stewardship regarding reviewing the findings of the antibiotic stewardship program with the Quality Assurance Improvement Committee. 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 ensure that all required members are present at the Quality Assurance and Improvement meetings ¿ All residents have the ability to be affected by the facility failing to ensure that the findings of antibiotic stewardship program are reviewed by the Quality Assurance Committee . What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The US FOIA (b)(6) were in-serviced on the facility's policy on antibiotic stewardship regarding reviewing the findings of the antibiotic stewardship program with the Quality Assurance Improvement Committee. ¿ The US FOIA (b)(6) were in-serviced that the facility is required to have an Infection preventionist present at the Quality Assurance and Improvement Meeting. ¿ The Quality Assurance and Improvement Meeting will only be scheduled after the confirmation of all	

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F 868	Continued From page 24 antibiotics while optimizing the treatment of infection, at the same time reducing the possible adverse events associated with antibiotic use. The Core Elements of stewardship ... tracking measures, reporting data ...about antibiotic resistance and opportunities for improvement ...5. Tracking, a. IP will be responsible for infection surveillance and MDRO (multi-drug resistant organisms) b. IP will collect and review data. 6. Reporting: a. IP and/or other members of the ASP team will review and report findings to facility staff and to QA committee. A review of the facility's policy, "Quality Assurance and Performance Improvement" reviewed 5/2024, revealed Policy: Our company is committed to developing, implementing, and maintaining an effective, comprehensive, date-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. g. iii. Several key options for identifying date collect, analyze, and apply the QAPI process are the following examples; ...15. Antibiotics, 17. Infections rates, 18. Infection Control Compliance.	F 868	required attendees. ¿ The Administrator/designee will audit the Quality Assurance and Improvement Meeting sign in sheet quarterly for attendance of required members. ¿ The Director Of Nursing/designee will audit the Quality Assurance and Improvement Meeting binder quarterly to ensure that Antibiotic Stewardship findings were presented to the Quality Assurance Committee.	
F 880 SS=D	NJAC 8:39-33.1(a)(b) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		4/10/25

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F 880	Continued From page 25 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880		

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F 880	Continued From page 26 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility documentation, it was determined that the facility failed to ensure laundry staff had the proper personal protection equipment (PPE) necessary to handle linens to prevent the spread of infection. This deficient practice was evidenced by the following: On 02/20/25 at 2:34 PM, the surveyor toured the laundry room with the[US FOIA (b)(6) redacted]. The surveyor observed 3 dryers in use and clean linens, which included patient johnny coats (hospital gowns), folded on a table. The tour continued into to the washing machine side. The surveyor observed empty linen carts. The surveyor did not observe any PPE. The surveyor asked the[US FOIA redacted] the process for sorting dirty laundry. He stated staff sorted the	F 880	How will the corrective action be accomplished for those residents found to be affected by this practice? Affecting all residents personal protective equipment placed in the laundry room. The[US FOIA (b)(6) redacted] and laundry staff were in-serviced that the personal protective equipment bins in the laundry room must be fully stocked at all times. The[US FOIA (b)(6) redacted] and laundry staff were in-serviced on the Personal protective equipment policy regarding proper handling of linen to ensure the safety of residents. 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	

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F 880	Continued From page 27 laundry by wearing gloves and a patient gown. He explained staff came in from the dryer side with the gown. He took the surveyor back to the dryer side and showed the surveyor the short-sleeved hospital gown. He stated staff wore the gown and then put it in the laundry when they were done with it. The surveyor asked if that was acceptable protection? The US FOIA responded "yes" but the US FOIA (b) responded, "no it is not, it should be a PPE gown." The US FOIA (b) verified that the staff should be wearing a long-sleeved disposable PPE gown for protection. The US FOIA (b)(6) all acknowledged there were no PPE gowns available on the dryer side or the washer side. On 2/21/25 at 1:09 PM, the surveyor made the US FOIA (b)(6) aware of the above findings in the presence of the survey team. A review of the facility's policy "Linen Handling for Nursing Personnel" revised 9/20/24 revealed Policy: To ensure the safety of residents and staff the facility will ensure proper handling of linen. A review of the facility's undated policy "Personnel Linen Handling for Residents on Isolation" revealed Policy: To ensure the safety of residents and staff the facility will ensure proper handling of linen for residents on Isolation. Objectives: To prevent the spread of communicable and infectious diseases through laundry and linen handling...Procedures: 6. The laundry staff personnel will perform hand hygiene the donn (put on) PPE (personal protective equipment) (gown, gloves) to handle contaminated linen. NJAC 8:36-19.4 (a) (b) (c)	F 880	by the facility failing to ensure that laundry staff have the proper personal protective equipment necessary to handle linens to prevent the spread of infection. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The US FOIA (b)(6) and laundry staff were in-serviced that the personal protective equipment bins in the laundry room must be fully stocked at all times. The US FOIA (b)(6) and laundry staff were in-serviced on the Personal protective equipment policy regarding proper handling of linen to ensure the safety of residents. Personal protective equipment competency evaluation repeated for the Director of Housekeeping and laundry staff. The Central Supply Manager will be assigned to monitor and stock the personal protective equipment supply for the laundry room. The Housekeeper/designee will audit the laundry room□s Personal protective equipment supply weekly for a month, monthly for 3 months and quarterly thereafter. 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 Housekeeping/designee	

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F 880	Continued From page 28	F 880	will review any findings of these audits and present them quarterly with the Quality Assurance and Performance Improvement committee to determine frequency of future audits.	
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility documents, it was determined that the facility failed to maintain an ongoing review for their Antibiotic Stewardship (AS) Program. This deficient practice was evidenced by the following: On 2/20/25 at 1:54 PM, the surveyor interviewed the US FOIA (b)(6) who stated she was the acting US FOIA (b)(6) since the last one had recently resigned. She stated she attended the quarterly Quality Assurance & Performance Improvement (QAPI) meeting and reports on infection control. The surveyor requested to review the AS. The US FOIA (b) requested the US FOIA (b)(6)) to join the meeting. At 2:19 PM, the US FOIA (b) joined the interview with 2	F 881	F881 ABS Annual Survey 2/14/25 Compliance Date: How will the corrective action be accomplished for those residents found to be affected by this practice? Affecting resident #15 All Nurses were in-serviced on how to use the NJ Ex Order 26.4b1 and importance of following NJ Ex Order 26.4b1 prior to giving antibiotics. All Nurses were in- serviced on reporting to the Physician when the resident does not meet the NJ Ex Order 26.4b1. The US FOIA (b)(6) were in-serviced on the facility□s policy on antibiotic stewardship regarding tracking, collecting data, and reviewing the findings of the antibiotic stewardship program with the Quality Assurance	4/10/25

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F 881	Continued From page 29 Antibiotic Stewardship binders, 2024 and 2025. The [redacted] stated the facility uses McGeer's Criteria (a set of guidelines used to define and diagnose healthcare associated infections (HIAs) in long-term care Facilities (LTCFs). The surveyor asked to be shown unsampled Resident #15's antibiotic tracking for January 2025. The [redacted] and the [redacted] reviewed the 2025 binder and acknowledged the resident was not in book .The surveyor asked how are you tracking and ensuring staff are following McGreers, making sure proper tests were done before antibiotics were started, such as an xray or urine culture? The[redacted] looked in the 2024 binder for December's AS binder and was unable to provide the evidence. The [redacted] stated that antibiotic monitoring was important because the main purpose was to "prevent incorrect use of antibiotic use and resistance." Neither binder was given to the surveyor at that time for review at that time. On 2/21/25 at 10:38 AM, during a follow up meeting with the surveyor, the [redacted] and the [redacted] Resident #15's [redacted] check list, dated [redacted] was reviewed which revealed the following under the [redacted] box, All three criteria must be present. -An empty box next to "Interpretation of [redacted] -An empty box next to "At least one of the following [redacted]." A check in the circle next to '[redacted]" -An empty box next to "At least one of the [redacted]" No circles were checked -[redacted]) for	F 881	Committee. 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 an ongoing review for the Antibiotic Stewardship program. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? All Nurses were in-serviced on how to use the McGreer□s criteria and importance of following McGreer criteria prior to giving antibiotics. All Nurses were in- serviced on reporting to the Physician when the resident does not meet the McGreer□s criteria. The Administrator and the Director of Nursing were in-serviced on the facility□s policy on antibiotic stewardship regarding tracking, collecting data, and reviewing the findings of the antibiotic stewardship program with the Quality Assurance Committee. The Infection Preventionist will keep the antibiotic stewardship binder up to date and review new antibiotic cases with the clinical team. The Infection Preventionist/designee will present the documentation related to the Antibiotic Stewardship findings to the Quality Assessment and Assurance committee for review quarterly. The Infection Preventionist/designee will audit the charts of residents who are receiving anti-biotic treatment for compliance with the McGreer□s criteria	

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F 881	Continued From page 30 NJ Ex Order 26.4b1). -A check in No for NJ Ex Order 26.4b1 " - A check in Yes for "NJ Ex Order 26.4b1 " -A check in NJ Ex O for "reportable to DOH" -Signed by US FOIA (b)(6) . At that time, the US FOIA (b) stated or NJ Exec Order 26.4 NJ Exec O started for Resident #15 and the doctor ordered the NJ Exec Order 26.4b1 and ordered an NJ Exec Ord She stated the nurse should have called the doctor and let them know that the resident did not meet the criteria for starting the NJ Exec Order 26.4b1 She further explained that it would be discussed with the medical director if the doctor still wanted to start the NJ Exec Order 26.4b1 She stated that there should be a progress note documenting the "time out of NJ Ex Order 26.4b1 and what was done. The US FOIA (b) verified a progress note was not done. On 2/25/25 at 12:48 PM, a review of the facility provided antibiotic stewardship binders for 2024 and 2025. The surveyor reviewed the book which revealed from July 2024 to present, all the data in book for each month was printed on 2/17/25 by the US FOIA (b), which was after survey started. On 2/25/25 at 1:05 PM, the surveyor interviewed the US FOIA (b)(6) who acknowledged the US F surveillance binder had not being updated. On 02/25/25 at 1:21 PM, the surveyor met with the US FOIA (b)(6) to review the facility's Quality Assurance and Performance Improvement (QAPI). The US FOIA (b)(6) reviewed the QAPI sign in sheets for 10/17/24 and verified he did not see where the US FO had signed in. The surveyor asked the US FOIA (b)(6) to show the AS Information that was reviewed with	F 881	weekly for 1 month, monthly for 3 months and quarterly thereafter. 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 Infection Preventionist/designee will review any findings of these audits and present them quarterly with the Quality Assurance and Performance Improvement committee to determine frequency of future audits.	

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F 881	Continued From page 31	F 881		

the committee. The [redacted] reviewed the QAPI binder and was unable to locate the AS data, he acknowledged that the other departments information was in the binder.

During that meeting, the [redacted] verified the [redacted] attended the 1/16/25 meeting, but the [redacted] was unable to show the AS information that was reviewed. He stated that usually the AS was printed and reviewed at the meeting. He then added the information could be pulled from the electronic medical record system for tracking. The surveyor made the [redacted] aware of the AS binders tracking from July 2024 to present were printed 2/17/25 by the CNO.

On 2/21/25 at 1:09 PM, the surveyor made the [redacted] the [redacted] and the [redacted] aware of the above findings in the presence of the survey team.

A review of the facility's policy, "Antibiotic Stewardship" reviewed 9/3/24 revealed. Policy: It is the policy of Carnegie Post Acute Care to implement an Antibiotic Stewardship program (ASP) which will promote appropriate use of antibiotics while optimizing the treatment of infection, at the same time reducing the possible adverse events associated with antibiotic use. The Core Elements of stewardship ...at a minimum, include these basic elements: Leadership, accountability, drug expertise, action to implement recommended policies or practices, tracking measures, reporting data ...about antibiotic resistance and opportunities for improvement ...5. Tracking, a. IP will be responsible for infection surveillance and MDRO (multi-drug resistant organisms) b. IP will collect and review data. 6. Reporting: a. IP and/or other

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F 881	Continued From page 32 members of the ASP team will review and report findings to facility staff and to QA committee.	F 881		
F 882 SS=E	NJAC 8:39-19.4 (d) Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documents, it was determined that the facility failed to have a designated US FOIA (b)(6) [redacted] dedicated solely to the infection prevention and control program (IPCP) and physically worked onsite in the facility. This deficient practice was evidenced by the following:	F 882	F882 IP Annual Survey 2/14/25 Compliance Date: How will the corrective action be accomplished for those residents found to be affected by this practice? Affecting all residents the US FOIA (b)(6) [redacted] were in-serviced that the facility is required to employ an on-site full time Infection Preventionist	4/10/25

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F 882	Continued From page 33 Reference: According to the NJ Executive Directive 21-012 (revised 12/22/22) included "The facility's designated individual(s) with training in infection prevention and control shall assess the facility's IPCP by establishing or revising the infection control plan, annual infection prevention and control program risk assessment, and conducting internal quality improvement audits." According to the CMS QSO-22-19-NH Memo dated 6/29/22 and Fact Sheet, Updated Guidance for Nursing Home Resident Health and Safety dated 6/29/22, effective date on October 24, 2022, Overview of New and Updated Guidance, Summary of Significant Changes, included that in Infection Control, requires the facilities to have a part-time IP. While the requirement is to have at least a part-time IP, the IP must meet the needs of the facility. The IP must physically work onsite and cannot be an off-site consultant or work at a separate location. IP's role is critical to mitigating infectious diseases through an effective infection prevention and control program. IP specialized training is required and available. On 2/14/25 at 10:13 AM, during entrance conference, the US FOIA (b)(6)) stated that the last US FO resigned approximately NJ Exec Order 26.4b1. He stated that facility had an interim US FOIA (b)(6) A review of the facility provided timeline of US FOIA revealed the following: IP #1 date of hire (DOH) was NJ Exec Order 26.4b1 to termination NJ Exec Order 26.4b IP #2 DOH NJ Exec Order 26 to termination NJ Exec Order 26.4	F 882	that meets the needs of the facility. The on-site, full time Executive Clinical Director was designated as the full time Infection Preventionist. 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 have a designated Infection Preventionist dedicated solely to the infection prevention and control program that physically works on-site in the facility . What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The US FOIA (b)(6) were in-serviced that the facility is required to employ an on-site full time Infection Preventionist that meets the needs of the facility. The on-site, full time Executive Clinical Director was designated as the Infection Preventionist. The facility will post the open Infection Preventionist position on job sites. The Administrator/designee will audit the staffing sheets to ensure that the on-site full time Infection Preventionist is scheduled, weekly x4 monthly for 3 months and quarterly thereafter. 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?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315370	A. BUILDING _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETON LLC	**5000 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) COMPLETION DATE
F 882	Continued From page 34 IP #3 DOH NJ Exec Order 26.4b to termination NJ Exec Order 26.4b IP #4 DOH NJ Exec Order 26.4b to termination NJ Exec Order 26.4b On 2/20/25 at 1:54 PM, the surveyor interviewed the US FOIA (b)(6) who stated she was the US FOIA (b)(6), since the last one had recently resigned. She stated she usually came to building 3 times a week for usually 8 hours each time and was in constant communication with the building. She acknowledged that US FOIA sole responsibility should be full time. She reviewed the above-mentioned US FO timeline and acknowledged the multiple lapses the facility did not have a designated US FO with the longest lapse of 2/24/24 to 6/2/24. She added she was the covering US FO during those times but was unable to show accountability for being in the building as the US FO during those lapses. The US FOIA (b) stated, "I know we are not in compliance with IP." On 2/21/25 at 1:09 PM, during a meeting with the survey team, the surveyor made the US FOIA (b)(6) aware of the above findings. A review of the facility's "Infection Preventionist Job Description" revealed Job Summary: the infection preventionist is responsible for the facility infection prevention and control program (IPCP0, which is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections ...Essential Function: ...Maintain current knowledge of federal state, and local regulations and ensure that the facility leader are informed of appropriate issues. Experience: Be qualified by education, training, experience, or certification in	F 882	The Administrator/designee will review any findings of these audits and present them quarterly with the Quality Assurance and Performance Improvement committee to determine frequency of future audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315370	A. BUILDING _____ B. WING _____	C 02/25/2025

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

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F 882	Continued From page 35 infection control. Must work at least part-time at the facility. NJAC 8:39-19.1(b)	F 882		

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
	62202	A. BUILDING: _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETO	5000 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
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 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	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for six (6) of 14 day shifts reviewed. This deficient practice was evidenced by the following: a. Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	S560 Annual Survey 2/14/25 Compliance Date: How will the corrective action be accomplished for those residents found to be affected by this practice? 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	4/10/25

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

Electronically Signed | 03/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62202	A. BUILDING: _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: 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 than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA 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. This deficient practice was evidenced by the following: The surveyor requested staffing for the weeks of 01/26/2025 to 02/08/2025 For the two (2) weeks of staffing prior to survey from 01/26/2025 to 02/08/2025, the facility was deficient in CNA for residents on six (6) of the 14 day shifts as follows: -01/26/25 had 14 CNAs for 145 residents on the day shift, required at least 18 CNAs. -02/01/25 had 17 CNAs for 149 residents on the day shift, required at least 19 CNAs. -02/02/25 had 15 CNAs for 149 residents on the day shift, required at least 19 CNAs. -02/03/25 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs.	S 560	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. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The facility will continue to post job openings on job sites to promote Certified Nursing Assistants position The facility is offering a sign on bonus The facility has contracted with multiple agencies to assist with our staffing needs The staffing coordinator/designee will offer staff the ability to pick up more shifts by placing a pick up shift sheet on Staffing Coordinators door. The administrator/designee will review the staffing sheets weekly x 4 then monthly for 3 months and quarterly thereafter. 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 any findings of these audits and present them quarterly with the Quality Assurance and Performance Improvement committee to determine frequency of future audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62202	A. BUILDING: _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETO	5000 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
S 560	Continued From page 2 -02/4/25 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs. -02/08/25 had 16 CNAs for 154 residents on the day shift, required at least 19 CNAs. On 02/21/25 at 10:22 AM, the surveyor interviewed the Staffing Coordinator (SC), who stated she was familiar with the staffing ratios, and she tried to meet ratios as best as she could but "then there are callouts." A review of the facility policy "Staffing" dated as reviewed 08/2024, provided by the Staffing Coordinator revealed, "It is the policy and procedure of this facility to adequately staff the facility in accordance with the NJ State guidelines." In addition, "The Staffing Coordinator along with the Director of Nursing and the Administrator will staff the building based on the census and acuity of the building a. In accordance with the NJ Staffing Ratio requirements: i. Day Shift - 1:8 (C.N.A. to Resident) ii. Evening Shift -1:10 (Direct Care Staff to Resident) iii. Night Shift- 1:14 (Direct Care Staff to Resident)."	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315370 Y1	A. Building B. Wing Y2	4/21/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETON LLC	5000 WINDROW DRIVE PRINCETON, NJ 08540

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0641	Correction	ID Prefix F0712	Correction	ID Prefix F0758	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.30(c)(1)-(4)	Completed	Reg. # 483.45(c)(3)(e)(1)-(5)	Completed
LSC	04/10/2025	LSC	04/10/2025	LSC	04/10/2025
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/25/2025	☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315370 Y1	A. Building B. Wing Y2	4/21/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETON LLC	5000 WINDROW DRIVE PRINCETON, NJ 08540

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0636	Correction	ID Prefix F0640	Correction	ID Prefix F0641	Correction
Reg. # 483.20(b)(1)(2)(i)(iii)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.20(g)	Completed
LSC	04/10/2025	LSC	04/10/2025	LSC	04/10/2025
ID Prefix F0712	Correction	ID Prefix F0758	Correction	ID Prefix F0868	Correction
Reg. # 483.30(c)(1)-(4)	Completed	Reg. # 483.45(c)(3)(e)(1)-(5)	Completed	Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed
LSC	04/10/2025	LSC	04/10/2025	LSC	04/10/2025
ID Prefix F0880	Correction	ID Prefix F0881	Correction	ID Prefix F0882	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(a)(3)	Completed	Reg. # 483.80(b)(1)-(4)	Completed
LSC	04/10/2025	LSC	04/10/2025	LSC	04/10/2025
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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/25/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
62202 Y1	A. Building B. Wing Y2	4/21/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETON LLC	5000 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 S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/10/2025	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/25/2025	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315370	A. BUILDING **01** B. WING _____	**02/25/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETON LLC	**5000 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) COMPLETION DATE
E 000	Initial Comments Carnegie Post Acute of Princeton was in compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 02/14/2025 and 02/18/2025 and Carnegie Post Acute of Princeton was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Carnegie Post Acute of Princeton is a three story - building that was built in the 1980's. It is composed of Type II protected construction. The facility is divided into 9 - smoke zones. The facility has a 350 Kilo Watt Diesel Emergency Generator that powers approximately 80 % of the building per the Director of Facilities. The current occupied beds are 156 of 180.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT	K 222		4/10/25

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

Electronically Signed | 03/13/2025

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315370	A. BUILDING **01** B. WING _____	**02/25/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 222	Continued From page 1 LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315370	A. BUILDING 01 B. WING _____	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETON LLC	5000 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) COMPLETION DATE
K 222	Continued From page 2 installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 02/14/2025 and 02/18/2025 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to provide 1 of 8 designated exit access /exit discharge (illuminated exit signs above door) doors within the means of egress, readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance NFPA 101, 2012 Edition, Sections 7.2.1.6.1 (4), 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice was evidenced by the following: On 02/14/2025 during the survey entrance at approximately 9:22 AM, a request was made to the US FOIA (b)(6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three-story (3) building with 8 designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency	K 222	How will the corrective action be accomplished for those residents found to be affected by this practice? ¿ Affecting all residents . The thumb turn lock has been removed from the administrative Suite egress designated exit. ¿ The Maintenance Employees were in-serviced on doors within the means of egress must be readily accessible and free of all obstructions or impediments to full instant use in case of fire or other emergencies. 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 ensure that doors within the means of egress are readily accessible and free of all obstructions or impediments to full instant use in case of fire or other emergencies. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315370	A. BUILDING **01** B. WING _____	**02/25/2025**

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

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K 222	Continued From page 3 to exit the building. Observations on 02/18/2025 at approximately 10:53 AM, revealed the Administrative suite designated exit discharge door (illuminated exit sign above the door) had a thumb turn lock on the egress side of the doors. The thumb turn lock and fastening device on the door could restrict emergency use of the designated exit discharge doors. A review of an emergency evacuation diagram posted in the corridor, identified the door was the primary exit discharge door in the event of an emergency. In an interview at the time of observation, the US FOIA (b) confirmed the finding. The US FOIA (b)(6) were informed of the deficient practice during the Life Safety Code survey exit on 02/18/2025 at approximately 2:15 PM.	K 222	recur? ¿ The Maintenance Employees were in-serviced on doors within the means of egress must be readily accessible and free of all obstructions or impediments to full instant use in case of fire or other emergencies ¿ The Director of Maintenance/designee will audit 4 egress exits to ensure that obstruction or impediment is present, weekly for a month, monthly for 3 months, and quarterly thereafter. 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 Maintenance/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine frequency of future audits.	
K 351 SS=D	NJAC 8:39 -31.2 (e) Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state	K 351		4/10/25

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	315370	A. BUILDING 01 B. WING _____	02/25/2025

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

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K 351	Continued From page 4 or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation on 02/14/2025 and 02/18/2025 in the presence of facility US FOIA (b)(6) [redacted]), it was determined that the facility failed to properly install sprinklers as required by CMS regulation §483.90(a) physical environment to all areas in accordance with NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and the National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. This deficient practice was observed in one non-resident area and was evidenced by the following: A observation on 02/18/2025 at approximately 11:54 AM, revealed inside the Environmental Services Directors office, one half of a 2-foot by 4-foot ceiling tile was missing and had evidence of water damage on the other half. A second ceiling tile where the fire sprinkler was located, had evidence of water damage and was hanging lower than the recessed sprinkler head in the room. With the opening in the ceiling, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system as designed.	K 351	How will the corrective action be accomplished for those residents found to be affected by this practice? ¿ Affecting all residents. The ceiling tiles inside the Environmental Services Director□s office have been replaced. ¿ The Maintenance Department was in-seviced on the proper installation of sprinkler systems including that all ceiling tiles must be present and intact not hanging lower than the sprinkler head. 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 properly install sprinklers. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The Maintenance Department was in-seviced on the proper installation of sprinkler systems including that all ceiling tiles must be present and intact not hanging lower than the sprinkler head. ¿ The Director of Maintenance will audit 3 smoke zones to ensure that all ceiling	

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	315370	A. BUILDING 01 B. WING _____	02/25/2025

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K 351	Continued From page 5 In an interview at the time of observation, the [US FOIA (b)] confirmed the findings. The [US FOIA (b)(6)] were informed of the deficient practice during the Life Safety Code survey exit on 02/18/2025 at approximately 2:15 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	tiles are in-place and intact with no water damage present, weekly for 1 month, monthly for 3 months, and quarterly thereafter. 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 Maintenance/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine frequency of future audits.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations on 02/14/2025 and 02/18/2025 in the presence of [US FOIA (b)(6)], it was determined that the facility failed to maintain the integrity of smoke barrier	K 372	How will the corrective action be accomplished for those residents found to be affected by this practice? ¿ Affecting all residents the holes	4/10/25

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	315370	A. BUILDING 01 B. WING _____	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 372	Continued From page 6 partitions for two (2) of nine (9) smoke barrier walls in accordance with NFPA 101:2012 Edition, Sections 19.3.6.2.3, 8.5.6, 8.5.6.2 and 8.5.6.3. This deficient practice had the potential to affect all 156 residents and was evidenced by the following: On 02/14/2025 (day one of survey) during the survey entrance at approximately 10:12 AM, a request was made to the US FOIA (b)(6) and the US FOIA (b) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. . A review of the facility provided lay-out identified the facility was a three-story (3) building with nine (9) smoke barrier walls. Observations on 02/14/2025 revealed the following: 1) An observation at approximately 11:06 AM on the 3rd. floor above the ceiling tiles by the double corridor smoke doors next to Resident room # 308 revealed one (1) approximately 1-inch in diameter hole with wires running through the smoke barrier wall. 2) An observation at approximately 12:20 PM on the 2nd. floor above the ceiling tiles by the double corridor smoke doors next to Resident room #208 revealed one (1) approximately 1-inch in diameter hole with wires running through the smoke barrier wall. In an interview at the time of observations, the US FOIA (b) confirmed the findings. The US FOIA (b)(6) and the US FOIA (b) were informed of	K 372	through the smoke barrier walls by the the double corridor smoke doors next to resident rooms #202 and #308 have been closed up. ¿ The Maintenance Employees were in-serviced on subdivision of building spaces related to maintaining the integrity of smoke barrier partitions. 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 integrity of smoke barrier partitions. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ The Maintenance Employees were in-serviced on subdivision of building spaces related to maintaining the integrity of smoke barrier partitions. ¿ The Director of Maintenance/designee will audit 3 smoke barrier partitions to ensure that no penetration is present, weekly for a month, monthly for 3 months, and quarterly thereafter. 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 Maintenance/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine frequency of future audits.	

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	315370	A. BUILDING **01** B. WING _____	**02/25/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 372	Continued From page 7 the deficient practice during the Life Safety Code survey exit on 02/18/2025 at approximately 2:15 PM. N.J.A.C 8:39-31.2(e)	K 372		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315370 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/21/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARNEGIE POST ACUTE CARE AT PRINCETON LLC	5000 WINDROW DRIVE PRINCETON, NJ 08540

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	04/10/2025	LSC K0351	04/10/2025	LSC K0372	04/10/2025
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	
2/25/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO