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 10/31/2024

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 Complaint #s: NJ00178815, NJ00178967 Census: 135 Sample: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		12/13/24

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

Electronically Signed | 11/15/2024

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 _____ B. WING _____	C 10/31/2024

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 609	Continued From page 1 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00178967 Based on interviews and review of pertinent facility documents on 10/31/24, it was determined that the facility failed to report an alleged NJ Ex Order 26.4(b) and its subsequent findings to the New Jersey Department of Health state agency and follow their facility policy on "Abuse, Neglect and Mistreatment of Residents" for a resident (Resident #1). The deficient practice was evidenced by the following: According to Resident #1's Admission Record (AR), Resident was admitted to the facility with diagnoses of that included but not limited to the following: NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) According to Resident #1's Minimum Data Set (MDS), an assessment tool that provides a comprehensive assessment of each resident's NJ Ex Order 26.4(b)(1), dated NJ Ex Order 26.4(b)(1) revealed Resident #1's Brief Interview for Mental Status (BIMS) score was NJ Ex which indicated Resident's cognition was NJ Ex Order 26.4(b)(1). Resident #1's MDS further showed Section GG-Functional Abilities which reflected the Resident NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 of her/his NJ Ex Order 26.4(b)(1) Review of the written email [electronic mail]	F 609	How will the corrective action be accomplished for those residents found to be affected by this practice? ¿ The U.S. FOIA (b) & U.S. FOIA (b) (6) were in-serviced on the facility policy and proper reporting of any alleged violations of abuse and its subsequent findings to the Department of Health. 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 report alleged violation of abuse and its subsequent findings to the Department of Health and failure to follow their policy on abuse and neglect and mistreatment of residents. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? ¿ All staff were in- serviced on the facility□s policy on abuse and neglect and mistreatment of residents. ¿ The Administrator/DON will review all incident reports weekly for a month monthly for three months and quarterly thereafter to determine if any of the incidents were reportable events and if yes were they reported to the Department of Health within the required time frame.	

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 10/31/2024

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 609	Continued From page 2 received by the U.S. FOIA (b) (6)) from Resident #1's family member NJ Exec Order 26.4b1 dated NJ Ex Order 26.4(b)(1) at 7:35 PM [evening] which according to the NJ Exec Order 26.4b1 the Resident "had been NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(after the Resident mentioned her/his NJ Ex Order 26.4(again to the NJ Exec Order 26.4b1 Resident's NJ Exec Order 26.4b1 stated, "I asked why NJ Ex Or [Resident] thought they NJ Ex Or and understand NJ Ex Or had been NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(as NJ Ex Or said! I asked why again, and NJ Exec [Resident] said so NJ Ex Or would not 'NJ Ex Order 26.4(b)(1)'." Review of the email response of the U.S. FOIA (b to the Resident's NJ Exec Order 26.4b1 dated NJ Ex Order 26.4(b)(1) at 6:23 PM [evening], showed " ...our policy and procedure is to initiate an investigation with any claim/allegation, which we have already started since you sent your concerns to us. We are conducting an investigation and will reach out to you once we conclude." Review of the document provided by the facility titled "INCIDENT SUMMARY" (IS) with Date of Incident: NJ Ex Order 26.4(b)(1) and under Incident: "On NJ Ex Order 26.4(b)(1), NJ Exec Order 26.4b1 name] emailed the U.S. FOIA (b) (6) that her NJ Ex Order 26.4 told her during a NJ Exec Order 26.4b1 call that NJ Ex Or was NJ Ex Order 26.4(b)(1) by having NJ Ex Order 26.4(b)(1). [Facility's Name] is a NJ Ex Order 26.4(b)(1) facility, therefore this claimed precipitated an investigation which was initiated immediately by the U.S. FOIA (b) (6) ." The IS showed under Conclusion: " ...based on the evidence found by the IDT [interdisciplinary team] using resident and staff statements, interviews, facility policies, and nursing assessment, the team concluded NJ Ex Order 26.4(b)(1) had been applied to [Resident's name]. The team can safely conclude that NJ Ex Order 26.4(b)(1) had been used on [Resident's name], as per NJ Ex O NJ Exec Order 26.4b1	F 609	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 x 3 with the Quality Assurance 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 10/31/2024

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 609	Continued From page 3 [Resident's NJ Exec Order 26.4b1 name] claim via email. However, upon review of [Resident's name] orders and care plan, NJ Exec uses NJ Ex Order 26.4(b)(1) which accounts for the NJ Ex Order 26.4(b)(1) [Resident's name] reported NJ Ex Order 26.4(b)(1) to NJ Ex O NJ Exec Order 26.4b1 [name]. According to [Resident's name]'s order the NJ Ex Order 26.4(b)(1) are applied each morning and removed prior to bedtime. Based on these findings the team is able to rule out any NJ Ex Order 26 or NJ Ex Order 26.4(b)(1 In the IS, under Interventions, one of which " ...Office of the Long-Term Care Ombudsman made aware." There was no documented evidence that the allegation was reported to the New Jersey Department of Health (NJDOH). In an interview of the surveyor with the U.S. FOIA (b) and U.S. FOIA (b) (6)) on 11/01/24 via the telephone, U.S. FOIA (b) stated notification of the allegation to Ombudsman was sent electronically and representative from Ombudsman office had been frequently visiting the Resident and was ongoing. U.S. FOIA (b) (6 stated "we tried to reach out to resident's NJ Exec Order 26.4b1 [name] but she declined care conference". Review of the facility's Policy and Procedure titled: "ABUSE, NEGLECT AND MISTREATMENT OF RESIDENTS POLICY", under "Procedure: 1. All incidents of abuse (actual or suspected) will be reported immediately to the Administrator/Designee ....3. The Adminstrator/Designee will notify the Department of Health within one (1) business day ..." NJAC 8:39-4.1(a) (5)(6) NJAC 8:39-9.4(f);Appx.B	F 609		

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 10/31/2024

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 was 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 facility document review on 10/31/2024, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 14 of 14 day shifts. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	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 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	12/13/24

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

Electronically Signed | 11/15/24

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 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 1 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 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for the weeks of 10/13/24 to 10/19/24 and 10/20/24 to 10/26/24. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -10/13/24 had 15 CNAs for 140 residents on the day shift, required at least 17 CNAs. -10/14/24 had 15 CNAs for 138 residents on the day shift, required at least 17 CNAs. -10/15/24 had 15 CNAs for 134 residents on the day shift, required at least 17 CNAs. -10/16/24 had 14 CNAs for 133 residents on the day shift, required at least 17 CNAs. -10/17/24 had 14 CNAs for 133 residents on the day shift, required at least 17 CNAs. -10/18/24 had 14 CNAs for 133 residents on the day shift, required at least 17 CNAs. -10/19/24 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs.	S 560	affected by the facility failing to meet the required minimum staff to resident ratio 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 post open CNA positions on job sites ¿ The facility will offer a sign-on bonus for newly hired CNAs. ¿ The Administrator and staffing coordinator will visit local CNA schools for recruiting purposes ¿ The facility will collaborate with local CNA schools to train students in the facility which will encourage graduates to join the facility□s staff ¿ The Administrator/designee will audit daily stuffing sheets daily for a week weekly for a month monthly for three 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 x 3 with the Quality Assurance 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 10/31/2024

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S 560	Continued From page 2 -10/20/24 had 14 CNAs for 133 residents on the day shift, required at least 17 CNAs. -10/21/24 had 14 CNAs for 137 residents on the day shift, required at least 17 CNAs. -10/22/24 had 15 CNAs for 137 residents on the day shift, required at least 17 CNAs. -10/23/24 had 14 CNAs for 137 residents on the day shift, required at least 17 CNAs. -10/24/24 had 14 CNAs for 137 residents on the day shift, required at least 17 CNAs. -10/25/24 had 14 CNAs for 136 residents on the day shift, required at least 17 CNAs. -10/26/24 had 14 CNAs for 136 residents on the day shift, required at least 17 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
315370 Y1	Y2	12/16/2024 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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 12/13/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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
10/31/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
62202		12/16/2024

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/13/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 10/31/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			