STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	90112	A. BUILDING: _____ B. WING _____	C 08/03/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00138109 CENSUS: 53 SAMPLE SIZE: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 391	8:36-4.1(a)(17) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 17. The right to be free from chemical and physical restraints, unless a physician, advanced practice nurse, or physician assistant authorizes the use for a limited period of time to protect the resident or others from injury. Under no circumstances shall the resident be confined in a locked room or restrained for	A 391		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 391	Continued From page 1	A 391		

punishment, for the convenience of the facility staff, or with the use of excessive drug dosages;

This REQUIREMENT is not met as evidenced by:
Complaint #NJ00138109

Based on observation, interview, and record review, it was determined that the facility violated the resident's right to remain [NJ Ex O] from being NJ Ex Order 26.4(b)(1) for the [NJ Ex Order 26.4(b)(1)] of the facility staff for 1 of 3 residents reviewed (Resident #1) . This deficient practice was evidenced by:

On 7/30/20, the Department of Health (DOH) received a Reportable Event Record/Report from the Facility. The report revealed that on [NJ Ex Order 26.4] at approximately 10 a.m., a staff member observed that Resident #1's apartment had a [NJ Ex O] and [NJ Ex Order 26.4(b)(1)] which [NJ Ex Order 26.4(b)(1)] the resident from NJ Ex Order 26.4(b)(1). Further review of the reportable event disclosed that the caregiver NJ Ex Order 26.4(b)(1) to [NJ Ex Order 26.4] the resident from [NJ Ex Order 26.4] and [NJ Ex Order 26.4(b)] staff. The report also revealed that the facility Executive Director (ED) and Director of Wellness (DOW) were not aware of the incident until [NJ Ex Order 26.4]. The ED also disclosed an additional caregiver was aware of the NJ Ex Order 26.4(b)(1) and that both caregivers and the Resident Concierge (RC) were suspended until the completion of the investigation.

Interview with the ED on 8/3/20 at 9:00 a.m. disclosed that the resident was moved to a

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

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A 391	Continued From page 2	A 391		

NJ Ex Order 26.4(b)(1) in order to follow the facility's policy of NJ Ex Order 26.4(b)(1) residents for 14 days upon return from the hospital in order to prevent the NJ Ex Order 26.4(b)(1). The ED told the surveyor that on NJ Ex Order 26.4 at approximately 9:30 a.m. he instructed the RC to go to the apartment to ensure that the apartment was equipped with proper furnishings. The ED told the surveyor that the RC met the Director of Maintenance (DOM) and both observed the NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1). In the presence of the ED, the surveyor observed the door and noted that the door was equipped with a NJ Ex Order 26.4(b)(1) and also observed a NJ Ex Order 26.4(b)(1) and NJ Ex Order secured to the wall directly outside the resident's apartment.

On 8/3/20 at 10:00 a.m. the surveyor reviewed the medical record for Resident #1 which revealed he/she was admitted to the NJ Ex Order 26 unit on NJ Ex Order 26.4(with diagnoses that included advanced NJ Ex Order 26.4(b)(1). Review of the Progress Notes (PN) contained within the resident's electronic medical record revealed that the resident was sent to the hospital on NJ Ex Order 26.4 and admitted for NJ Ex Order 26.4(b) The PN revealed that the resident returned to the facility on NJ Ex Order 26.4(and was "placed in a new room for NJ Ex Order 26.4(b)(1

At 10:15 a.m., the surveyor interviewed the DOM who stated that he observed the NJ Ex Order 26.4(b)(1) and described the NJ Ex Order 26.4(b)(1) as a NJ Ex Order 26.4(with NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(1). He stated that he told the RC that the door should not be NJ Ex Order 26.4(b)(1) and further stated that he was called away from the area to handle an emergency and forgot about the incident. He stated he did not NJ Ex Order 26.4(b)(1).

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A 391	Continued From page 3 At 11:10 a.m., the surveyor interviewed the Activities Director (AD) who stated that on [NJ Ex Order 26.4] she went to the office that she shared with the RC. She disclosed that she accompanied the RC to the resident's apartment and observed a [NJ Ex Order 26.4(b)(1)] and to the [NJ Ex Order 26.4(b)] The AD stated that the RC told her that the RC notified the DOW and wanted to find a caregiver to [NJ Ex Order 26.4(b)(1)]. The AD revealed that neither she or the RC [NJ Ex Order 26.4(b)(1)] from the [NJ Ex Order 26.4(b)(1)]. The AD revealed that the [NJ Ex O] was eventually [NJ Ex Order 26.4(b)] by a caregiver. At 12:00 p.m., the surveyor interviewed the DOW who revealed that on [NJ Ex Order 26.4] the RC came to her office and told her that the resident's [NJ Ex Ord] had a [NJ Ex Order 26.4(b)(1)] The DOW disclosed that she was not told the [NJ Ex Ord] was [NJ Ex Order 26.4(b)(1)] with this [NJ Ex Order 26.4(b)(1)] She instructed the RC to go to the apartment and [NJ Ex Order 26.4(b)(1)] as it was considered to be a [NJ Ex Order 26.4(b)(1)]. The DOW told the surveyor that the RC did not [NJ Ex Order 26.4] the [NJ Ex Order 26.4(b)(1)] but instead went to the office of the AD and brought the AD to the resident's apartment to see the [NJ Ex Order 26.4(b)(1)]. The DOW further disclosed that upon investigation the caregiver admitted to [NJ Ex Order 26.4(b)(1)] to prevent the resident from [NJ Ex Order 26] the apartment because the resident was [NJ Ex Order 26.4(b)] the caregiver through the unit. The surveyor observed the listing of resident rights posted above the resident mailboxes in a common area. The ED and the DOW agreed that the resident should not have been [NJ Ex Order 26.4(b)] for the [NJ Ex Order 26.4(b)(1)] of the staff member. The ED and the DOW further agreed that it was approximately [NJ Ex Order 26.4] between the time the [NJ Ex O] was first observed and the [NJ Ex Order 26.4]	A 391		

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A 391	Continued From page 4 of the [NJ Ex O] although multiple staff members were aware of its presence.	A 391		
A 473	8:36-5.1(g) General Requirements (g) The assisted living residence, comprehensive personal care home, or assisted living program shall adhere to applicable Federal, State, and local laws, rules, regulations, and requirements. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ00138109 Based on interview and record review, it was determined that the facility failed to notify the police of a case of [NJ Ex Order 26.4(b)(1)] as required under New Jersey State Law N.J.S.A 52:27G-7.1 This deficient practice was evidenced by: On 7/30/20, the Department of Health (DOH) received a Reportable Event Record/Report from the facility which revealed that on [NJ Ex Order 26.4] a staff member [NJ Ex Order 26.4(b)(] a resident from [NJ Ex Order 2] his/her apartment. Further review of the reportable event disclosed that a caregiver [NJ Ex Order 26.4(b)(1)] to [NJ Ex Order 26.4] the resident from [NJ Ex Order 2] and [NJ Ex Order 26.4(b] staff. The report also revealed that the facility Executive Director (ED) and Director of Wellness (DOW) were not aware of the incident until [NJ Ex Order 26.4]. Interview with the ED on 8/3/20 at 9:00 a.m.	A 473		

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A 473	Continued From page 5 disclosed that Resident #1, 1 of 3 residents sampled, was moved on NJ Ex Order 26.4 to a temporary apartment in order to follow the facility's policy of NJ Ex Order 26.4(b)(1) residents for 14 days upon return from the hospital in order to prevent the NJ Ex Order 26.4(b)(. The ED confirmed that on NJ Ex Order 26.4 for approximately NJ Ex Order 2 the resident was NJ Ex Order 26.4 in his/her room by a staff member who NJ Ex Order 26.4(b)(1) to a NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4(b)(to a NJ Ex Order 26.4(b)(1) . This action prevented the resident from NJ Ex Order 26.4(b)(1) the apartment. The ED confirmed that the police were not notified by the facility of the staff to resident NJ Ex Order 26 The surveyor confirmed with the DOW during the 12:00 p.m. interview that she was not aware of the requirement to notify the police in accordance with the statute.	A 473		
A 517	8:36-5.6(b)(1-7) General Requirements (b) The facility or program shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following: 1. The provision of services and assistance in accordance with the concepts of assisted living and including care of residents with physical impairment; 2. Emergency plans and procedures; 3. The infection prevention and control program;	A 517		

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A 517	Continued From page 6 4. Resident rights; 5. Abuse and neglect; 6. Pain management; 7. The care of residents with Alzheimer's and related dementia conditions and in accordance with N.J.A.C. 8:36-19. This REQUIREMENT is not met as evidenced by: Complaint #NJ00138109 Based on interview and review of in-service records and personnel files it was determined that the facility failed to provide documented evidence to confirm that 4 of 7 employees received the minimum required in-service education and training upon hire and then annually including resident rights and abuse prohibition. This deficient practice was evidenced by the following: 1. Employee #2 with a date of hire of NJ Ex Order 26.4(b)	A 517		

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A 517	Continued From page 7 had no documented evidence of receiving annual in-service training on Resident Rights and Abuse training. 2) Employee #5 with a date of hire of [NJ Ex Order 2] had no documented evidence of receiving in-service training upon hire on Resident Rights and Abuse Training. 3) Employee # 6 with a hire date of [NJ Ex Order 2] had no documented evidence of receiving in-service training upon hire on Resident Rights and Abuse Training. 4) Employee # 7 with a hire date of [NJ Ex Order 26.4(b] had no documented evidence of receiving in-service training upon hire on Resident Rights and Abuse Training. . Review of the facility policy "Protecting and Ensuring Resident Rights" revealed that "All staff will receive training on resident rights during orientation then annually thereafter." Review of the facility policy "Neglect/Abuse Identification, Suspected and Reporting" disclosed "All personnel shall be trained in regard to recognizing and reporting neglect or abuse." The ED disclosed to the surveyor during interview at 3:00 p.m. that the facility was not able to access the training partners website for several weeks. The ED confirmed that he was not able to verify that all training had been completed upon hire and then annually thereafter as required.	A 517		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
90112		9/2/2020

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0391 Reg. # 8:36-4.1(a)(17) LSC	Correction Completed 08/31/2020	ID Prefix A0473 Reg. # 8:36-5.1(g) LSC	Correction Completed 08/31/2020	ID Prefix A0517 Reg. # 8:36-5.6(b)(1-7) LSC	Correction Completed 09/30/2020
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
8/3/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO