STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315445	A. BUILDING _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR AT LAUREL CIRCLE, THE	**100 MONROE STREET BRIDGEWATER, NJ 08807**

(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 #: NJ00163106 Census: 41 Sample Size: 4 The facility is not compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. Survey date: 4/6/2023 and 4/10/2023	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00163106 Based on interviews, and record review, as well as review of pertinent facility documents on 4/6/23 and 4/10/23, it was determined the facility failed to; a. administer medications according to *Ex Order 26. 4B1* and notify the Physician for not administering the medication; b. to provide the correct diet according to the [redacted] in accordance with the current standards of practice and facility protocol for 1 of 4 residents (Resident #2) reviewed. This deficient practice is evidenced by the following: 1. According to the facility *Ex Order 26. 4B1*	F 658	F 658 SS= D. Services provided meet Professional Standards CFR(s): 483.21(b)(3)(i) It is the practice of Laurel Circle to ensure that medications are administered in a safe and timely manner and as prescribed. All medication orders are supported by appropriate care processes and practice. What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident number two does not reside in the community any longer.	5/24/23

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

Electronically Signed | 05/24/2023

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 658	Continued From page 1 Resident #2 was admitted on Ex Order 26. 4B1 and discharged on Ex Order 26. 4B1 with diagnoses that included but were not limited to: Ex Order 26. 4B1 . The Ex Order 26. 4B1, undated, revealed that Resident #2 had diagnoses of Ex Order 26. 4B1 . Interventions included but were not limited to: Give medications as ordered and liquids should be Ex Order 26. 4B1 . a. The Ex Order 26. 4B1 , dated Ex Order 26. 4B1 reflected a Ex Order for Ex Order 26. 4B1 give Ex.Order 26.4(b)(by mouth Ex.Order 26.4(b)(1) a day for Ex Order 26. 4B1 with Ex Order 26. 4B1 . The Ex Order 26. 4B1 reflected the aforementioned order for Ex Order 26. 4B1 . However, on 2/23/23 at 9:00 pm and on 2/24/23 at 9:00 am the Ex Order 26. was initialed by a nurse and grayed out. Review of the Ex Order 26. 4B1 indicated that if the Ex Order 26. was grayed out, the medication was not administered. Review of Resident #2's progress notes (PN) did not indicate that Ex Order 26. 4B1 was/was not administered or that the Physician was notified that the Ex Order 26. 4B1 was not administered on 2/23/23 at 9:00 pm and on 2/24/23 at 9:00 am. During the interview with the surveyor on 4/6/23 at 3:00 pm, Registered Nurse (RN #1), who worked on 2/23/23 during 3:00 pm to 11:00 pm shift, confirmed that Resident #2 was admitted on Ex Order 26. 4B1 during 3:00 pm to 11:00 pm shift. The RN stated that the resident's medications/orders were	F 658	How you will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. All residents have the potential to be affected by this alleged deficient practice. A review of all active residents and physicians' orders was conducted and no-like residents were identified. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur. All Licensed professional staff were in serviced on 4/6/23 by the ADON on the policy and procedure for ordering, receiving and transcribing of medication. The policy and procedure on medication administration and documentation was also reviewed. Medications will be administered in accordance with the orders, including any required time frame. The attending physician will be notified if medication is not available. The community has engaged the pharmacy and arranged a QA meeting to discuss timely medication delivery for new admissions and readmissions, including adding Ex Order 26. 4B1 and some other medication to the backup box on April 5th, 2023. The Unit Manger or designee will review physicians' orders for all new admissions and readmission daily 5 times a week for 90 days. Discrepancies will be brought to the attention of the director of nursing for additional follow-up. The Unit Manager/Designee will ensure all medications for new admissions and	

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F 658	Continued From page 2 reconciled and approved by the resident's primary physician. RN #1 further stated that the orders was faxed to the pharmacy on Ex.Order 26.4(b)(1) (unable to recall time). RN #1 stated that Ex Order 26. 4B1 was not administered because it was not delivered from the pharmacy and was not available in the facility's back up medication box. RN #1 was unable to recall if he notified the physician that the Ex. Order 26. 4B1 was not administered. During the interview with the surveyor on 4/10/23 at 11:24 am, the Licensed Practical Nurse (LPN#1), who worked on Ex.Order 26.4(b)(1) during 7:00 am to 3:00 pm shift, confirmed that the 9:00 am dose of Ex Order 26. 4B1 was not administered to Resident #2 because the medication was not available and it was not available in the facility's medication back up box. LPN #1 stated that he did not remember if he called the Pharmacy and the primary physician to notify them that the medication Ex Order 26. 4B1 was not delivered or that the medication was not administered to Resident #2. He also stated that he did not document the reason why the medication was not administered in the *Ex Order 26. 4B1* because "there was so many things going on." During the interview with the surveyor on 4/6/23 and 4/10/23, the Director of Nursing (DON) stated that Ex Order 26. 4B1 was not administered to Resident #2 because the medication was not delivered from the pharmacy on Ex.Order 26.4(b)(1). The DON further stated that the nurse should have called the pharmacy to inquire why it was not delivered, notified the physician that the medication was not given and documented the notification in the Ex Order. During the interview with the surveyor on 4/10/23 at 12:42 pm. the physician stated she was not	F 658	readmissions have been delivered or followed up with pharmacy for delivery of medications in a timely manner. Medications not delivered or available will be brought to the attention of the director of nursing. The Director of Nursing /ADON will perform random checks of the Clinical Smart Board and Message Board to ensure medications for new admissions and readmissions are administered per policy. The audit will be reviewed to identify any trends and brought to the quality assurance performance improvement committee. The policy and procedure on admission criteria and admission check list was reviewed with all nursing professionals, reiterating the importance of following through with the admission process and having a second nurse double check all orders. Ex Order 26. 4B1 will be provided to the dietary department after physician's orders are reviewed and approved by the physician. The facility will review resident diets upon admission and update any changes as needed. The unit manager/Designee will review diets for all residents on admission and monthly to ensure diets are provided according to physician orders. The dietitian will review diets upon admission and weekly to ensure diets are provided as prescribed. The 11-7 nurse will review all admissions and readmission orders for accuracy and compliance.	

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F 658	Continued From page 3 made aware that the medication Ex Order 26. 4B1 was not administered to Resident #2 on 2/23/23 and 2/24/23. b. Review of the 'Ex Order 26. 4B1 " dated Ex.Order 26.4(b)(1 3 reflected a Ex Order order for Ex Order 26. 4B1 . Review of Resident #2's Ex Order 26. 4B1 provided to the kitchen by Registered Nurse (RN #1), dated Ex.Order 26.4(b)(1 at 4:15 pm reflected that the resident's Ex Order 26. 4B1 was Ex Order 26. 4B1 and Ex Order 26. 4B1 was Ex Order 26. 4B1 which was not according to the Ex Order 26. During the interview with the surveyor on 4/6/23 at 3:08 pm, RN #1 confirmed that Resident #2 was admitted on Ex Order 26. 4B1 during 3:00 pm to 11:00 pm shift. The RN stated that the resident's orders were reconciled and approved by the resident's primary physician. However, the RN stated that the Ex Order 26. ticket was sent to the kitchen was for Ex Order 26. 4B1 instead of the Ex Order 26. 4B1 The RN explained that the Ex Order 26 were not double-checked with another nurse because the staff were "busy." The surveyor conducted an interview with the Dietary Supervisor (DS) on 4/6/23 at 3:38 pm. The DS revealed that on 2/23/23 during dinner time, Resident #2's tray was prepared with a regular Ex Order instead of the physician ordered Ex Order 26. 4B1, which was not according to the Ex Order 26. The DS further revealed that she received a call from the nurse's station asking her to replace the resident's tray according to the Ex Order 26. The DS prepared and delivered the second tray according	F 658	When Ex Order 26. 4B1 is completed by nursing and sent to the kitchen, the Health Center Kitchen Manager/Designee will monitor trays of new admission to ensure that the food served on tray for each resident is according to the Ex Order 26. 4B1 specified on the Ex Order 26. 4B1. Education has been provided to members of the dietary department. How the facility will monitor its corrective action(s) to ensure that the deficient practice will not recur, (i.e. What quality assurance or other program will be put in place to monitor the continued effectiveness of the systemic change) The Director of Nursing will report the findings of this monitoring process to the QAPI committee monthly for three months for review and further recommendations to ensure ongoing substantial compliance. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction for each deficiency and the completion date for each component. The Director of Nursing will be responsible for sustaining compliance on or before 5/24/23.	

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F 658	Continued From page 4 to the [redacted] *Ex Order 26. 4B1* [redacted] However, upon delivering the second tray to the resident's room the responsible party (RP) noted that the water consistency was incorrect, and the DS reported it to the nurse. According to the DS, she replaced the [redacted] *Ex Order 26. 4B1* [redacted] Review of the facility "Concern/Grievance Form (CGF)," dated 2/24/23, reflected that the resident's responsible party (RP) reported that "[Resident #2] had not received [redacted] *Ex Order 26. 4B1* [redacted] medication, and that [she/he] had been given the wrong [redacted] order the previous night." The CGF indicated that the Dietary and the Director of Nursing were informed of the concerns. The CGF further indicated "dietician reports that tray was removed immediately, and appropriate [redacted] was provided. Resident did not consume any part of the wrong [redacted] ...DON reports waiting for delivery of the medication. DON is to have medication in our back up box." Review of the facility '[redacted] *Ex Order 26. 4B1* [redacted] Legend", undated, reflected "1. [redacted] *Ex Order 26. 4B1* [redacted] that are printed or viewed on a computer screen will have the following appearance ...B. If a medication was not administered the initial will be present but the box next to the administration time will be grayed out." The facility policy titled "Administering Medications", dated 12/2012, reflected "Policy Statement Medications shall be administered in a safe and timely manner, and as prescribed ...3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered	F 658		

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F 658	Continued From page 5 within one (1) power of their prescribed time, unless otherwise the specified (for example, before and after meal orders) ..." NJAC 8:39-11.2(b) NJAC 8:39-27.1(a)	F 658		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00163106 Based on interviews, and record review, as well as review of pertinent facility documents on 4/6/23 and 4/10/23, it was determined the facility failed to provide the correct *Ex Order 26. 4B1* according to the physician's order for 1 of 4 sampled residents (Resident #2) reviewed for Ex Order [redacted]. This deficient practice is evidenced by the following: 1. According to the facility '*Ex Order 26. 4B1*" Resident #2 was admitted on Ex Order 26. 4B1 and discharged on Ex Order 26. 4B1 with diagnosis that included but was not limited to: Ex Order 26. 4B1. The *Ex Order 26. 4B1*, undated, revealed that Resident #2 had Ex Order 26. 4B1. Interventions included but was not limited to: Liquids should be *Ex Order 26. 4B1* [redacted].	F 805	F805 SS=D. Food in Form To Meet Individual Needs CFR(s): 483.60(d)(3) It is the practice of Laurel Circle for Nursing services to notify the food and nutrition services department of a resident's diet order, including any changes in the resident's Ex Order, meals services and food preferences. ' What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident number two no longer resides at the community. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this deficient practice; A review of all resident's Ex Order orders,	5/24/23

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F 805	Continued From page 6 Review of the 'Ex Order 26. 4B1 [redacted], dated 2/23/23 reflected a diet order for Ex Order 26. 4B1 [redacted]. Review of the facility "Concern/Grievance Form (CGF)," dated 2/24/23, reflected that the resident's responsible party (RP) reported that [she/he] had been given the wrong Ex Order [redacted] order the previous night." The CGF indicated that the Dietary department and the Director of Nursing (DON) were informed of the aforementioned concern. The CGF further indicated "dietician reports that tray was removed immediately and appropriate Ex Order [redacted] was provided. Resident did not consume any part of the wrong Ex Order [redacted]..." Review of Resident #2's 'Ex Order 26. 4B1 [redacted] provided to the kitchen by Registered Nurse (RN #1), dated 2/23/23 at 4:15 pm reflected that the resident's Ex Order 26. 4B1 was Ex Order 26. 4B1 [redacted] was Ex Order 26. 4B1 [redacted] which was not according to the Ex Order 26. [redacted]. During the interview with the surveyor on 4/6/23 at 3:08 pm, Registered Nurse (RN #1) revealed that prior to the resident ' s admission, he received a call from the sending hospital on Ex Order 26. 4B1 [redacted] regarding the resident ' s information ' s which included but not was limited to the resident ' s diet which was Ex Order 26. 4B1 [redacted] The RN explained he prepared and provided the Ex Order 26. [redacted] to the kitchen prior to the resident ' s arrival. The RN further explained that Resident #2 was admitted on Ex Order 26. 4B1 [redacted] during 3:00 pm to 11:00 pm shift, the resident's medications/orders were reconciled and approved by the resident's primary physician but was not double-checked with	F 805	including residents with Ex Order 26. 4B1 [redacted] was conducted and no like residents were identified. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and, Immediate education on Ex Order [redacted] orders, and Ex Order 26. 4B1 [redacted]. was conducted for all nursing and dietary staff by the ADON 4/5/23 and 4/6/23. The dietary supervisor has completed re training regarding. identifying Ex Order 26. 4B1 [redacted] and following Ex Order [redacted] orders. Food and nutrition services and nursing staff will inspect food trays to ensure that the correct consistency is provided to each resident. The Health Care Kitchen Manager will ensure that follow-up in-services on prescribed consistency is provided to all dietary staff monthly for three months. How facility will monitor its corrective action(s) to ensure that the deficient practice will not recur (i.e., what quality assurance or other program will be put into place to monitor the continued effectiveness of the systemic change), The Director of Nursing will conduct random checks of up to five admission diet orders weekly for one month and then weekly for three months. The Health Center Kitchen Manger will conduct 5 food tray audits to evaluate accuracy of prescribed consistency weekly for one month then monthly for three months. Results of the audits will be reviewed during the monthly Quality Assurance and Performance Improvement committee	

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F 805	Continued From page 7 another nurse, per facility protocol, because the staff were "busy" and "didn ' t have time to double-check the [redacted] order versus the [redacted]. RN #1 stated that the [redacted] he sent to the kitchen was *Ex Order 26. 4B1* instead of the physician ordered *Ex Order 26. 4B1*. The RN further stated that on 2/23/23 during dinner (unable to recall exact time), the kitchen prepared and delivered a wrong [redacted] to the resident, which consisted of a regular *Ex Order 26. 4B1* and [redacted] instead of the physician ' s ordered [redacted] of *Ex Order 26. 4B1*. The RN confirmed that he did not feed Resident #2 with the regular [redacted] and [redacted], the tray was untouched and a replacement with the correct [redacted] was brought up. The RN stated that Resident #2 required Ex.Order 26.4(b)(1) [redacted]. The surveyor conducted an interview with the Dietary Supervisor (DS) on 4/6/23 at 3:38 pm. The DS revealed that on 2/23/23 during dinner time, Resident #2 ' s tray was prepared with a regular [redacted] instead of [redacted] which was not according to the [redacted]. The DS further revealed that she received a call from the nurse ' s station asking her to replace the resident ' s tray according to the [redacted]. The DS prepared and delivered the second tray according to the [redacted] *Ex Order 26. 4B1* However, upon delivering the second tray to the resident's room the *Ex Order 26. 4B1* noted that the water consistency was incorrect, and the DS reported it to the nurse. According to the DS, she replaced the *Ex Order 26. 4B1* to *Ex Order 26. 4B1* The surveyor conducted an interview with the Certified Nursing Assistant (CNA #1) on 4/10/23 at 11:06 am. CNA #1 confirmed that Resident #2	F 805	meeting, and concerns will be reviewed and addressed. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction for each deficiency and the completion date for each component. The Director of Nursing will be responsible for sustaining compliance on or before May 24th, 2023	

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F 805	Continued From page 8 required Ex.Order 26.4(b)(1) [redacted]. The CNA stated that "the kitchen delivered the wrong [redacted], the tray had whole chicken leg and [redacted]. I didn't feed the resident; I was removing the tray from [Resident #2] room when RP walked into the room." Review of the Dietary Aide job description, dated 4/2015, indicated "GENERAL SUMMARY: The Dietary Aide is responsible for preparing and serving [redacted] trays to Health Center residents in accordance with posted [redacted] menus. the dietary aid is also responsible for maintaining safety and sanitation regulation at all times." During the interview with the surveyor on 4/6/23 at 10:42 am, the Health Care Kitchen Manager (HCKM) stated that the kitchen aides (KA) were to prepare food according to the [redacted]. The KA ' s had to look at the [redacted] and prepare according to the [redacted]. Review of "HealthCare Dietary Aid Job Flow, undated, reflected under "Job Flow Position 3...You are the checker. Check food against ticket. What is their [redacted]? Are they on a [redacted]? Are they on [redacted]? Do they have a [redacted]? Have their preferences been met..." Review of the Tray Line Training, undated, reflected [redacted] NJAC 8:39-17.4(a)(1)(2)	F 805		

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
315445 Y1	A. Building B. Wing Y2	6/5/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR AT LAUREL CIRCLE, THE	100 MONROE STREET BRIDGEWATER, NJ 08807

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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 05/24/2023	ID Prefix F0805 Reg. # 483.60(d)(3) LSC	Correction Completed 05/24/2023	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	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
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 4/10/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			