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 07/14/2023

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

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E 000	Initial Comments This facility is in substantial 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		
F 000	INITIAL COMMENTS Complaint NJ #: 160923; 162847; 163467; 163777; 163901; 164512 STANDARD SURVEY: 7/14/23 CENSUS: 42 SAMPLE SIZE: 15 + 3 + 1 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 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		8/31/23

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

Electronically Signed | 07/31/2023

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 607	Continued From page 1 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: NJ Complaint #162847 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) develop their [redacted] policy in accordance with the requirement to report any *Ex Order 26. 4B1* to the New Jersey Department of Health (NJDOH) immediately or within two hours, and b.) implement their [redacted] policy by immediately notifying administration, starting an investigation, and contacting the NJDOH for an *Ex Order 26. 4B1* that occurred on 3/18/23. This deficient practice was identified for 1 of 4 residents reviewed for [redacted] (Resident #17), and the evidence was as follows: On 7/7/23 at 11:31 AM, the surveyor observed Resident #17 in the dayroom participating in activities. The surveyor reviewed the medical record for	F 607	F607 SS=D. Develop/Implement Abuse/Neglect Policies F607 CFR(s): 483.12(b)(1)-(5)(ii)(iii) It is the practice of Laurel Circle to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #17 still resides at the community. The investigation has been completed and the resident was assessed on [redacted]. Resident #17 is [redacted]. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.	

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F 607	Continued From page 2 Resident #17. A review of the Face Sheet (admission summary) reflected the resident was admitted to the facility in Ex Order 26. 4B1 with diagnoses which included Ex Order 26. 4B1 . A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec. Order 26:4.b, included a brief interview for mental status (BIMS) score of a [redacted] out 15, which indicated a Ex Order 26. 4B1 . A review of the Clinical Notes Report included a Nursing Note authored by Licensed Practical Nurse (LPN #1) dated NJ Exec. Order 26:4.b at 3:00 PM, that as per the 11:00 PM to 7:00 AM (11-7) nurse, resident had NJ Exec. Order 26:4.b.1 most of the shift without incident. [He/she] can be seen propelling [him/herself] on [his/her] wheelchair on the hallway. A further review included a Nursing Note authored by LPN #1 dated NJ Exec. Order 26:4.b.1 at 2:53 PM, that the resident complained of NJ Exec. Order on [his/her] Ex Order 26. 4B1 this morning when the Certified Nursing Aide (CNA) was about to do Ex Order 26. 4B1 . I went and assessed the situation, the area was slightly Ex Order 26. 4B1 , NJ Exec. Order 26:4.b.1 . The Physician was made aware, and she ordered a Ex Order 26. 4B1 of the Ex Order 26. 4B1 to rule out Ex Order 26. 4B1 . The order was carried out and Ex Order 26. 4 was done. The paper result was pending. An as needed Ex Order 26. 4B1 was given with very good effect	F 607	All residents have the potential to be affected by this deficient practice. A total of nineteen residents without Ex Order 26. 4B1 were interviewed by the Social Worker on 7/31/23 and no-like residents were identified. Interview questions included □ How was your stay? Have you had any issues or concerns? and Are you satisfied with how staff are treating you? A Ex Order 26. 4B1 was conducted by nursing on 7/31/23 for eighteen (18) residents who are not good historians and there is no indication of Ex Order 26. 4B . What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and, The policy and procedure on Ex Order 26. 4B1 , Neglect and reporting was reviewed and revised by Administrator and Medical Director on 7/14/23. On 7/14/23 the Director of Nursing conducted in-services for Licensed Nursing staff on identifying and reporting abuse and neglect including immediate reporting to the Director of Nursing and Nursing home administrator as well as completion of an immediate investigation. Ex Order 26. 4B1 will be thoroughly investigated and reported within 2 hours of Ex Order 26. 4B1 .by the Administrator /Designee. 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),	

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F 607	Continued From page 3 as resident was observed using [redacted] without [redacted] A review of a Nursing Note authored by the Unit Manager dated [redacted] at 4:32 PM, included [redacted] result to [redacted] shows an [redacted]. I assessed the [redacted] that is [redacted]. There is a [redacted] noted around the [redacted]. On 7/10/23 at 10:00 AM, the surveyor requested from the Director of Nursing (DON) to provide all investigations, accidents, incidents, grievances, and reportable events for Resident #17 from the past year. On 7/11/23 at 8:52 AM, the DON provided the requested investigations and confirmed they were complete investigations with all statements. A review of the reportable event submitted to the NJDOH on [redacted], indicated on [redacted] at 4:00 PM, the resident (Resident #17) stated to the CNA that [he/she] was [redacted] on the [redacted]; no individual was identified. (This was documented in the Nursing Notes that the resident [redacted] someone [redacted] them on their [redacted] on [redacted], on [redacted], it was documented in the Nursing Notes that the resident complained of [redacted] and an [redacted] was obtained which resulted in a [redacted].) The reportable continued that an investigation was started; skin checked was completed; physician and family notified; staff interviews were conducted; and summary and conclusion to follow. A review of the statement provided included a Nurses/CNA Incident/Accident Statement Form	F 607	Results of five audits for timely completion and reporting will be reviewed during the community's monthly Quality Assurance and Performance Improvement committee for review for compliance; additional concerns will be reviewed and addressed as appropriate. This review will be done for three months, and adjustments will be made for compliance below 100% The Director of Nursing will be responsible for sustaining compliance on or before August 31st, 2023.	

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F 607	Continued From page 4	F 607		

dated [redacted] and signed [redacted] by Registered Nurse #1. The statement indicated that resident claimed a [redacted] came in and [redacted] [him/her] with a box on the [redacted]; resident was assessed with NJ Exec. Order 26:4.b.1 [redacted]. The resident denied that CNA #1 (his/her assigned CNA) [redacted] them.

A review of the Statement Form dated date of incident [redacted] and signed by CNA #1 on [redacted], indicated that she was assigned to Resident #17 on [redacted] during the 11-7 night shift, and around 12:00 AM (on [redacted]), the resident transferred themselves from their bed to wheelchair and was very [redacted] stating [redacted]. I informed the supervisor who assisted the resident back to bed, and around 6:00 AM (on [redacted]), I went to change the resident who stated they *Ex Order 26. 4B1* called because someone [redacted] them. CNA #1 continued that she notified RN #1 who assessed the resident, and the resident reported that CNA #1 was not the person who [redacted] him/her.

A review of an undated Statement Form signed by CNA #2 dated [redacted], indicated on [redacted] and [redacted], he took care of Resident #17 with no concerns, and on [redacted], they complained of their [redacted] hurting stating they [redacted], and I called the nurse.

A review of the undated Investigation Summary indicated on [redacted] during the 11-7 night shift, [RN #1] reported to the oncoming [LPN #1] for the 7:00 AM to 3:00 PM (7-3) day shift that the resident was up all night and [redacted] looking for their spouse. The resident informed [CNA #]1 that he/she was [redacted] on the [redacted] by a [redacted]. The resident was assessed by the nurse and no

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F 607	Continued From page 5 NJ Exec. Order 26:4.b.1 noted to their Ex Order 26. 4B1, and declined NJ Exec. Orde medication. On 3/22/23 the resident complained of Ex Order 26. 4B1 NJ Exec. Or and he/she was assessed by the nurse with noted Ex Order 26. 4B1 and the resident was administered NJ Exec. Orde and the physician ordered an Ex Order 26. 4. The Ex Order 26. 4 revealed Ex Order 26. 4B1 of a Ex Order 26. 4B1 of the Ex Order 26. 4B1. The resident was sent to the Ex Order 26. 4B1 for a Ex Order 26. 4, and the physician documented the resident had Ex Order 26. 4B1 . Staff and patient interviews conducted, and staff did not observe any incident. Conclusion was Ex Order 26. 4B1 cannot be substantiated. On 7/11/23 at 9:17 AM, the surveyor interviewed the DON who stated that any incident or Ex Order 26. 4B1 was immediately investigated. Staff attempt to interview the resident if possible and any staff who might be involved based on the incident that occurred. The facility went back two shift and interviewed all nurses and CNAs that were assigned to the resident and any staff who may have come in contact with the resident. The DON stated the facility investigated Ex Order 26. 4B1, Ex Order 26. 4B1, and injury of unknown origin. The DON stated Ex Order 26. 4B1 was reported right away to the NJDOH along with unknown events with injury and elopements. On 7/12/23 at 12:30 PM, the surveyor interviewed LPN #1 stated there was an incident that occurred one night, cannot recall the exact date but the night nurse informed him that the resident had complained of NJ Exec. Orde in the Ex Order 26. 4B1 that had observed NJ Exec. Order 26:4.b.1, so an Ex Order 26. 4 was ordered, and	F 607		

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F 607	Continued From page 6 the resident had a *Ex Order 26. 4B1* and was sent to the [redacted] for a [redacted]. LPN #1 stated he was the one to call the physician to get the order for the [redacted] and administered the [redacted], but the night nurse was the nurse who assessed the resident; the incident was only endorsed to him because it was change of shift. On 7/13/23 at 9:50 AM, the surveyor interviewed RN #1 via telephone who stated there were two situations with Resident #17; the first the resident stated someone [redacted] him/her but the resident was assessed and there was NJ Exec. Order 26:4.b.1 [redacted] RN #1 stated the resident on another day, complained of [redacted] to [redacted] when the CNA was changing them, so I went in and assessed the resident and saw NJ Exec. Order 26:4.b.1 [redacted]. RN #1 stated it was at change of shift, so he endorsed it to the oncoming nurse. RN #1 thought he documented it in the computer. On 7/13/23 at 10:26 AM, the surveyor re-interviewed the DON who stated that any *Ex Order 26. 4B1* [redacted], staff went back three shifts and interviewed all staff members who were a witness or took care of the resident immediately. The surveyor reviewed with the DON the reportable dated 3/24/23, that indicated that the resident complained someone hit them on [redacted] The surveyor reviewed the Nursing Notes with the DON, and reviewed the note dated [redacted] which the DON confirmed the *Ex Order 26. 4B1* [redacted] occurred on [redacted]. When questioned why the nurse and CNA's statements were for [redacted] but dated signed on [redacted] and [redacted] respectively, the DON stated sometimes staff was not in the building and could not interview right away.	F 607		

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F 607	Continued From page 7 On 7/14/23 at 9:34 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), Assistant Director of Nursing/Infection Preventionist (ADON/IP), and the survey team stated that when the facility investigated the resident's [redacted] on [redacted], it was then brought to administration's attention that the resident had an *Ex Order 26. 4B1* on [redacted]. The DON stated that staff never reported to them the *Ex Order 26. 4B1* [redacted] from [redacted], so the facility investigated both situations together. The DON stated that both RN #1 and LPN #1 were written up for not reporting an *Ex Order 26. 4B1*, and [redacted] was ruled out for the [redacted] because the physician documented the resident had *Ex Order 26. 4B1* [redacted]. The DON stated everything was investigated together since the facility only learned through investigating the [redacted] that the resident [redacted] on [redacted]. At this time, the surveyor requested to see [redacted] training for RN #1, LPN #1, CNA #1, and CNA #2 as well as if the four staff members had *Ex Order 26. 4B1* against them. On 7/14/23 at 10:41 AM, the LNHA provided [redacted] training for all four staff members and stated there have been no *Ex Order 26. 4B1* made against them. The LNHA stated all staff including nurses and CNAs have been educated on reporting abuse, and any staff member could have informed the DON or LNHA of the [redacted]. The LNHA stated the incident occurred on the weekend, and staff should have contacted the DON or himself so the situation could have been immediately investigated. A review of the facility's "Abuse Prevention Program" policy dated November 2017, included	F 607		

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F 607	Continued From page 8 it is the policy of this community to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion...Identification of Allegations and Internal Reporting Requirements: Employees are required to report any incident, allegation, or suspicion of potential abuse, neglect, or misappropriation of property they observe, hear about, or suspect immediately to the administrator or the person in charge of the community, acting on behalf of the administrator, or immediate supervisor who must then immediately report it to the administrator...if a crime, particularly physical or sexual abuse, is suspected, it must be reported to the state agency and local law enforcements under the following timeframes: serious bodily injury - immediately but no later than two hours after forming a suspicion...Investigation of Abuse, Neglect, or Misappropriation Allegation and Response: all incidents will be documented, whether or not abuse occurred, was alleged or suspected. any incident or allegation involving abuse, neglect or misappropriation will result in an abuse investigation...upon discovery of a bruise, skin tear, or any resident injury of unknown origin, an investigation will be initiated...Initial Reporting of Allegations: any allegations of abuse will be reported to the administrator immediately and the State Department of Health and resident's representative as soon as possible with twenty-four hours....within five working days after the report of occurrence, a complete investigation and conclusion of the investigation, including steps the community has taken response to the allegation, will be sent to the Department of Health...	F 607		

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F 607	Continued From page 9	F 607		
F 677 SS=D	NJAC 8:39-4.1(a)(5); 13.4 (c)2i-2vi ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a Ex Order 26. 4B1 resident who was dependent on staff for Ex Order 26. 4B1 was physically assisted with meals to prevent Ex Order 26. 4B1. This deficient practice was identified for 1 of 15 residents reviewed for Ex Order 26 care (Resident #13), and was evidenced by the following: On 7/10/23 at 12:17 PM, the surveyor observed Resident #13 in their room eating lunch feeding themselves. The resident questioned the surveyor several times what they were eating, they stated they could not see what was on the plate. The surveyor observed that the resident was eating a whole sweet potato and grilled chicken that was cut in large pieces, and part of the chicken was not cut all the way through and still intact whole; a salad with ranch dressing, pudding, macaroni salad, and an unopened container of apple juice and water. The surveyor observed an empty chair next to the resident's tray table, and the surveyor asked the resident if someone should be assisting them with Ex Order 26. 4B1, and the resident stated Ex Order 26 The surveyor observed the resident pick-up food with a fork	F 677	F677 ADL Care Provided for Dependent Residents F677 CFR(s): 483.24(a)(2 It is the practice of Laurel Circle to provide patients with care, treatment and services appropriate to maintain their ability to carry out activities of daily living (ADLs). What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. On 7/14/23 the resident summary was updated to reflect the ADL needs for resident #13 including providing assistance with Ex Order 26. 4B1. Resident #13 was evaluated by the NJ Exec. Order 26:4.b.1. Residents #13□s NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4 interventions were added. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents have the potential to be affected by this deficient practice. A community wide audit of ADL support with feeding was conducted by the Assistant Director of nursing on 7/14/23. Ex Order 26. 4B1	8/31/23

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F 677	Continued From page 10 from the plate and dropped the food off the fork. The surveyor asked the resident if they had difficulty seeing, and they did not respond. On 7/10/23 at 12:20 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that Resident #13 was Ex Order 26. 4B1 and could not NJ Exec. Order 26:4.b.1. The LPN continued that the resident was Ex Orde by staff because they had a poor appetite needing encouragement and could not NJ Exec. Order 26:4.b.1 was on the plate, so they often dropped food from their fork. The LPN stated the resident was not at risk for choking as to why they needed to be Ex Orde, but staff needed to physically sit with the resident to feed them. On 7/10/23 at 12:23 PM, the surveyor accompanied by the LPN went into the resident's room, and the LPN confirmed someone should be Ex Order 26. 4B1 Resident #13. The LPN introduced themselves to the resident and informed them that they would assist them with Ex Order 26. 4B1 as the resident confirmed they could NJ Exec. Order 26:4 what they were eating. The LPN opened the resident's apple juice and offered them a drink, which the resident accepted as the LPN proceeded to Ex Order 26 him/her. On 7/10/23 at 12:34 PM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated he generally took care of Resident #13 daily, so he was familiar with the resident. The CNA stated the resident had Ex Order 26. 4B1, but he/she Ex Orde themselves as long as staff cut the food for them. The CNA stated that he did not have to Ex Order 26 the resident; he just had to bring in the tray and cut the food up. The surveyor asked the CNA how they were informed of the resident's	F 677	assistance was added to the resident summary and assignment sheets. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All nursing staff will be re-educated by ADON/Designee on how to find information for ADLs assistance for all residents including assistance with meals on or before 8/7/23. Resident summaries will be initiated by the charge nurse for all residents on admission and will include ADL support during mealtimes. The resident summary will be updated when a change in status is identified, quarterly, and as needed thereafter. The CNA assignment form will include ADL assistance required at meals and will be initiated and updated daily by the Unit Manager/Designee. The DON or designee will audit of up to five resident summaries for feeding assistance weekly for four weeks, then monthly for two months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? This corrective action will be monitored by the Community Quality Assurance and Performance Improvement Committee. The DON/Designee will be responsible for completing five audits weekly on resident summaries, including ADL support during meals for four weeks and then monthly for 2 months. Results will be submitted to the Quality Assurance and Performance	

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F 677	Continued From page 11 [redacted] assistance needs, and the CNA brought the surveyor to the computer system at the wall. The CNA showed that he documented the level of assistance provided to the resident for their [redacted] each shift, but he stated the program did not include what level of assistance the resident needed. The CNA went under the care plan tab in the computer system, which did not include the resident's [redacted] assistance needs. On 7/10/23 at 12:42 PM, the surveyor asked the Director of Nursing (DON) how the CNAs were informed of the level of assistance and care residents needed, the DON stated that the nurses received a daily report, and the aides could view the care plan. The DON provided the surveyor with a list of all residents, which included Resident #13 was a [redacted]. The surveyor asked the DON what a [redacted] meant, and she replied that someone would be physically assisting them with [redacted]. The surveyor asked how the CNA would be made aware, and she informed the surveyor to ask the Assistant Director of Nursing/Infection Preventionist (ADON/IP) who was also the staff educator. On 7/10/23 at 12:48 PM, the surveyor interviewed the ADON/IP who stated the nurses were aware of the resident's assistance needs for their [redacted] from the report provided to the surveyor by the DON. The surveyor reviewed the report with the ADON/IP who confirmed Resident #13 was a [redacted], so they needed assistance with [redacted]. The ADON/IP stated the nurse was responsible for letting the CNA know that, but if the CNA was their regular aide, then they should know that. The ADON/IP confirmed that the CNA did not have any task or report to know the resident's required [redacted] assistance.	F 677	Improvement Committee for review and additional concerns will be reviewed and addressed as appropriate. Date of compliance: The Director of nursing will ensure compliance as of 8/31/23.	

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F 677	Continued From page 12 On 7/10/23 at 12:55 PM, the surveyor re-interviewed the LPN who confirmed she received a copy of that report that indicated Resident #13 was a [redacted], but the CNA was not provided that report. On 7/10/23 at 1:01 PM, the DON informed the surveyor that the CNA would know the resident's [redacted] assistance needs in the "Cares" section of the computer program, and to ask the ADON/IP to show me. On 7/10/23 at 1:04 PM, the ADON/IP reviewed the "Cares" section of the computer program with the surveyor for Resident #13, and the ADON/IP confirmed it did not include the resident's need for physical assistance with meals. The surveyor reviewed the medical record for Resident #13. A review of the Face Sheet (admission summary) reflected that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted] A review of the admission Minimum Data Set (MDS), an assessment tool dated [redacted] reflected the resident had a [redacted] score of [redacted] out of 15, which	F 677		

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F 677	Continued From page 13 indicated a [redacted]. A further review in Sect G. [redacted], that the resident required extensive assistance of a [redacted] assist for [redacted] A review of the individualized comprehensive care plan effective [redacted] to present, that the resident had [redacted]. Interventions included to offer [redacted] as needed such as identifying location of food on plate...A further review included a problem area for a decline in [redacted]. Interventions included [redacted] to evaluate and treat per physician order, assist with [redacted]; identify level of assistance needed and complete resident summary or nursing assistant assignment of care. A review of the July 2023 Physician Order Sheet included a physician's order dated [redacted] to assist with [redacted] The surveyor reviewed the CNA Assignment sheets from 7/1/23 until 7/10/23, the date of the observation, which revealed the CNA was assigned to Resident #13 on 8 of the 10 days. On 7/14/23 at 9:34 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), ADON/IP, and survey team confirmed that Resident #13 should have been assisted by staff [redacted], which included a staff member being present. A review of the facility provided "Activities of Daily Living (ADL), Supporting" policy dated revised March 2018, included residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out	F 677		

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F 677	Continued From page 14 activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene...appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with consent of the resident and in accordance with plan of care, including appropriate support and assistance with:...d. dining (meals and snacks)... NJAC 8:39-27.1(a)	F 677		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to conduct yearly performance reviews of Certified Nursing Aides (CNA) in order to provide specific education based on the outcomes of the reviews. This deficient practice was identified for 5 of 5 CNAs whose personnel records were reviewed, and was evidenced by the following: On 7/12/23 at 2:10 PM, the surveyor requested from the Director of Nursing to provide the most recent performance evaluation for five randomly selected Certified Nursing Aides (CNA #1; #2; #3;	F 730	F730 SS=F Nurse Aide Perform Review – 12hr/yr In-Service CFR(s): 483.35(d)(7) It is the practice of Laurel Circle to complete performance evaluations every twelve months and provide education based on the outcomes of these reviews. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified as affected by the deficient practice. How you will identify other residents	8/31/23

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F 730	Continued From page 15 #4; and #5). On 7/13/23 at 9:05 AM, the Licensed Nursing Home Administrator (LNHA) provided the survey team with the five selected CNAs performance evaluations. The LNHA stated the facility had not completed any performance evaluations for the employees since 2021, that the facility wanted to change their performance evaluation process from completing on the date of the employees anniversary to a set date for the year for all employees. The surveyor reviewed the performance evaluations provided by the LNHA which revealed the following: 1. CNA #1 was hired on Ex Order 26. 4B1. The last performance evaluation was completed January 2021, and signed by the employee on 1/15/21. 2. CNA #2 was hired on Ex Order 20. 4B1. The last performance evaluation was completed 12/13/21, and signed by the employee on 12/13/21. 3. CNA #3 was hired on Ex Order 20. 4B1. The last performance evaluation was completed on 2/11/21, and signed by the employee on 2/11/21. 4. CNA #4 was hired on Ex Order 26. 4B1. The last performance evaluation was completed December 2020, and signed by the employee on 12/7/2020. 5. CNA #5 was hired on Ex Order 26. 4B1. There was no performance evaluation provided. On 7/14/23 at 8:37 AM, the surveyor interviewed the LNHA who stated that Human Resources	F 730	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. The Director of Human Resources completed an audit of all CNA performance reviews on 7/27/23; CNA's who have not had a performance review in the last 12 months will be completed by the Director of Nursing or designee on or before 8/31/23. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and, On 7/18/23 the Health Center Administrator reviewed and revised the Employee Performance Evaluation policy and procedure. On 7/17/23 the administrator provided education to the Director of Human Resources and Director of Nursing on policy revisions and role responsibilities. The Director of Nursing will complete all performance reviews for CNA's identified in the community wide audit on or before 8/31/23. The community will schedule ongoing performance reviews for CNA's to be completed annually in April. The Director of Human Resources will log completion of annual reviews. The Director of Human Resources or designee shall perform audits of up to ten employee files for completion of annual performance reviews monthly for three months. How the facility will monitor its corrective action(s) to ensure that the deficient	

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F 730	Continued From page 16 (HR) was responsible for performance evaluations in combination with the Director of Nursing (DON) and himself. On 7/14/23 at 8:56 AM, the surveyor conducted a telephone interview with HR, who confirmed she was responsible for performance evaluations. HR stated that the facility identified performance evaluations were not being completed yearly, that no evaluations were completed in 2022. HR stated that the facility has piloted a program that all employees were to be reviewed at the same time each year for consistency. At this time, there are no completed evaluations. On 7/14/23 at 9:34 AM, the LNHA in the presence of the DON, Assistant Director of Nursing/Infection Preventionist (ADON/IP), and survey team confirmed there were no additional performance evaluations; that they were not completed annually as required. A review of the facility provided "In-Service Training Program, Nurse Aide" policy dated revised October 2017, included the facility will complete a performance review of nurse aides at least every twelve months. In-service training will be based on the outcome of the annual performance reviews, addressing weakness as identified in the reviews... NJAC 8:39-43.17(b)	F 730	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 Human Resources /designee will perform audits of ten employee files monthly for three months. Any findings will be immediately addressed for completion of the performance review. Results of the audits will be reported, and addressed for compliance, at the monthly community Quality Assurance and Performance Improvement Committee meeting. 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 Human Resources will be responsible for sustained compliance on or before 8/31/23.	
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry	F 802		8/31/23

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F 802	Continued From page 17 out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure dietary staff had the appropriate competencies and skill sets to effectively use and maintain the facility's high temperature dish machine. This deficient practice had the potential to affect all residents, and was evidenced by the following: During a follow-up visit to kitchen on 7/13/23 10:09 AM, the surveyor conducted an inspection of the dish machine, that was not currently in use, in the presence of the Executive Chef. The Executive Chef stated the facility utilized a high temperature dish machine and the gauges should read minimum of 160 degrees Fahrenheit (F) for wash and minimum of 180 F for rinse. The Executive Chef sent an empty tray through the dish machine, and the surveyor observed the wash gauge which read 150 F and the rinse gauge that read 148 F. The surveyor questioned	F 802	F802 SS=F Sufficient Dietary Support Personnel CFR(s): 483.60 (a)(3)(b) It is the practice of Laurel Circle to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of food and nutrition service in accordance with the facility assessment. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified as affected by the deficient practice. 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.	

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F 802	Continued From page 18 the temperatures, and the Executive Chef stated that he might be mistaken, that the machine might be a low temperature dish machine that utilized a chemical sanitizing solution that required lower temperatures. The Executive Chef picked up a bottle that contained a pink solution which he stated was sanitizer. At this time, the surveyor requested to see the facility's dish machine temperature log for the month of July 2023. The surveyor reviewed the July 2023 High Temperature Dishwasher Log in the presence of the Executive Chef which revealed for the month of July, the final rinse was recorded between 145-165 F when checked three times a day. The log indicated final rinse should be between 180-190 F; to report temperatures higher than 190 F or below 180 F for the final rinse to the manager. The Executive Chef, who during a previous kitchen visit informed the surveyor that he had worked at the facility for eight months now, stated that he was unsure the type of dish machine used at the facility, and he needed to contact the [Dish Machine Repair Company] to follow-up and he would let the surveyor know. On 7/13/23 at 2:10 PM, the surveyor in the presence of the survey team, informed the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the Assistant Director of Nursing/Infection Preventionist (ADON/IP) that they were still waiting to hear back from the Executive Chef what type of dish machine the facility used. The LNHA informed the survey team that he was unsure the type of dish machine the facility used, but the [Dish Machine Repair Company] was currently in the kitchen. At this time, the surveyor requested to	F 802	The Director of Food Services completed an audit of all dietary staff including the Executive Chef and line cooks on competencies on use of dish washer, sanitation and logging of temperature on 7/14/23. The Director of Food Services will conduct an in-service to the kitchen staff including the Executive Chef and line cooks on the workings of the dishwashing machine on or before 08/15/2023. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and, On 07/21/2023 the Health Center Administrator reviewed and revised the policy and procedure titled Sanitation and Cleaning Policy. Job descriptions and on job training competencies were also reviewed. On 07/21/2023 the administrator provided education to the Director of Food Services on policy revisions and role responsibilities. The Director of Food services will review job descriptions and the use of equipment including the use of dishwasher, sanitation and cleaning procedure, and logging of temperatures on or before 08/15/2023. All new kitchen staff will be provided with education on use of the dishwasher, sanitation and cleaning procedures, logging of temperature at orientation. The Director of Food Services or designee will complete all audits and log them appropriately. The Director of Food Services or designee shall perform audits of the kitchen staff including line cooks operating	

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F 802	Continued From page 19 speak with the Dish Machine Repair Employee #1. On 7/13/23 at 2:19 PM, the Food Service Director (FSD) in the presence of the LNHA, DON, and ADON/IP informed the survey team that "from my understanding" the dish machine was high temperature. The FSD stated that Dish Machine Repair Employee #1 conducted a test with a digital temperature recording plate that measured the maximum surface temperature in the dish machine which was 160 F that was okay. The surveyor informed the FSD that the July 2023 High Temperature Dishwasher Log for the entire month was recorded that the dish machine did not reach 180 F for the entire month. The FSD acknowledged this. On 7/13/23 at 2:20 PM, Dish Machine Repair Employee #1 in the presence of the FSD, LNHA, DON, and ADON/IP informed the survey team that the facility had a high temperature dish machine that should reach 160 F for the wash cycle and 180 F for the final rinse cycle. Dish Machine Repair Employee #1 stated that when he tested the internal temperature of the machine using digital temperature recording plate, the surface temperature reached 160 F which was acceptable per federal code, and in his opinion, the gauges were not operating correctly. At this time the surveyor requested to view the test. On 7/13/23 at 2:32 PM, Dish Machine Repair Employee #1 in the presence of the surveyor, FSD, and Executive Chef ran the digital temperature recording plate through the high temperature dish machine. The surveyor observed the gauges on the dish machine to read 155 F for wash and 148 F for rinse, and the digital	F 802	the dishwasher and including monitoring the temperatures weekly for one month then monthly for three months. 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 into place to monitor the continued effectiveness of the systemic change), The Director of food services /designee will audit 5 employee files on competencies on use of equipment including the use of dish washer, sanitation, cleaning procedures and logging of temperatures weekly for four weeks then monthly for three months. The results of the audits will be tracked and reviewed during the community's monthly Quality Assurance and Performance Improvement committee meeting for review for compliance; additional concerns will be addressed as appropriate. 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 Food Services will be responsible for sustained compliance on or before 8/31/2023.	

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F 802	Continued From page 20 temperature recording plate indicated the surface temperature was 160 F. Dish Machine Repair Employee #1 showed the surveyor the manufacturer's specifications which indicated at 160 F, the temperature effectively sanitized ware surfaces in accordance with the Food and Drug Administration (FDA) Food Code section 4-501. On 7/13/23 at 2:32 PM, the surveyor in the presence of the Executive Chef and FSD interviewed Utility Worker #1 who stated he worked at the facility for *Ex Order 26. 4B1*, and his job along with Utility Worker #2 was to wash dishes. Utility Worker #1 stated he recorded the dish machine temperatures yesterday, but Utility Worker #2 completed the log for today. Utility Worker #1 stated that he thought the temperatures needed to be between 160 F and 180 F, that the temperatures were not specific for the wash and rinse, just a temperature range. Utility Worker #1 stated that the wash temperature usually went up to 170 F. The surveyor reviewed the High Temperature Dishwasher Log with Utility Worker #1 and showed him where it indicated final rinse 180-190 F. Utility Worker #1 stated that he was aware the log indicated 180 F, but no one at the facility educated him that the temperature had to be above 180 F. At this time, the FSD and Executive Chef confirmed they educated kitchen staff with in-services and confirmed they had not conducted a dish machine in-service. The FSD and Executive Cook both confirmed they do not review the High Temperature Dishwasher Log unless staff gave it to them. At this time, the surveyor reviewed the May and June 2023 High temperature Dishwasher Logs with the FSD, which revealed for the months of	F 802		

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ARBOR AT LAUREL CIRCLE, THE	**100 MONROE STREET BRIDGEWATER, NJ 08807**

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F 802	Continued From page 21 May and June, temperatures were recorded within acceptable range. The FSD confirmed the recorded temperatures in question were just for the month of July 2023. On 7/13/23 at 2:47 PM, the Executive Chef in the presence of the LNHA informed the surveyor that Dish Machine Repair Employee #1 contacted the usual service technician (Dish Machine Repair Employee #2) who informed them that there was a third gauge located towards the back of the dish machine that recorded the final rinse temperature, that no one was aware of. The Executive Chef stated that gauge was reading 180 F. The Executive Chef confirmed no one in the kitchen was aware of this gauge, and he acknowledged that was concerning. On 7/14/23 at 9:10 AM, the surveyor observed the FSD with Dish Machine Repair Employee #1 and Dish Machine Repair Employee #2 at the facility's dish machine. Dish Machine Repair Employee #2 stated that the two water gauges in the front of the dish machine were the internal temperature gauges for the wash cycle, and the third temperature gauge towards the back of the machine recorded the final rinse temperature which had to be 180 F. Dish Machine Repair Employee #2 stated the facility only had a high temperature dish machine meaning that the final rinse needed to reach 180 F to sanitize; that the machine did not use a chemical sanitizing solution. Dish Machine Repair Employee #2 stated that the pink solution the Executive Chef mistook for sanitizer, was dish detergent and did not sanitize. The surveyor observed an empty dish rack run through the dish machine and the final rinse gauge read 180 F.	F 802		

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F 802	Continued From page 22 At this time, the FSD stated that the facility had utilized paper products since surveyor inquiry yesterday while the [Dish Machine Repair Company] has been here. The FSD acknowledged that he was unaware of the third water gauge that was for the final rinse temperature; as well as no other staff in the kitchen was aware. On 7/14/23 at 9:34 AM, the LNHA in the presence of the DON, ADON/IP, and survey team confirmed the facility had been utilizing paper products since survey inquiry; that there have been no reported gastrointestinal issues for the month for residents. The LNHA acknowledged the above concerns. No additional information was provided as to how the High Temperature Dishwasher Logs of May and June of 2023 where documented within acceptable range. The facility did not provide any dish machine in-services conducted prior to surveyor inquiry. A review of the facility provided "Sanitation" policy dated 2013, included...utility workers will be trained in the proper use of the dish machine and three-compartment sinks. Dish machine temperatures will be taken three times a day and recorded in log...	F 802		
F 812 SS=D	NJAC 8:39-17.1(a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		8/30/23

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F 812	Continued From page 23 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a.) handle potentially hazardous foods and maintain sanitation in a safe, consistent manner designed to prevent foodborne illness and b.) maintain kitchen equipment in a manner to prevent microbial growth. This deficient practice was evidenced by the following: On 7/7/23 at 10:14 AM, the surveyor toured the kitchen with the Executive Chef and observed the following: 1. On a rack in the walk-in freezer, six baked pies, not dated or covered. The pies were exposed to air. The Executive Chef confirmed the pies should be dated and covered. 2. On a drying rack, one large white cutting board discolored yellow and deeply pitting. The Executive Chef confirmed the cutting board	F 812	F812 SS=D Food Procurement, Store/Prepare/Serve- Sanitary CFR(s): 483.60(i)(1)(2) It is the practice of Laurel Circle to procure food from sources approved or considered satisfactory by federal, state, or local officials. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified as affected by the alleged deficient practice. 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. On 7/17/23 The Director of Food Service conducted a kitchen audit All undated and uncovered items were immediately	

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F 812	Continued From page 24 should be discarded because of the potential for bacterial growth. The Executive Chef stated that cutting boards were usually discarded after six months of use, but he could not speak to the last time cutting boards were changed. 3. On a spice storage rack, one 32-ounce (oz) bottle of lime juice labeled opened 6/26/23. The packaging indicated to refrigerate after opening. 4. On a spice storage rack, one 48-oz bottle of lemon juice dated received 6/27/23. The Executive Chef confirmed the bottle was opened and not dated when opened. The packaging indicated to refrigerate after opening. 5. On a storage rack under the preparation table, four large white, two large green, and six large red cutting boards. The cutting boards were all deeply pitted and discolored. The Executive Chef confirmed they should not be used. 6. In dry storage, one bulk container of thickener that contained a scoop stored directly in the thickener. The Executive Chef confirmed scoops should not be stored inside the bins. On 7/14/23 at 9:34 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON), Assistant Director of Nursing (ADON), and survey team acknowledged the above concerns. A review of the facility provided "Sanitation" policy dated 2013, included it is the policy of the community to store, prepare, distribute and serve food under sanitary conditions... A review of the facility provided "Food Storage"	F 812	discarded. Open items requiring refrigeration in dry storage and thickener was discarded. Cutting boards noted with discoloration and deep pitting were discarded. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and, On 7/17/23 the Health Center Administrator and Medical Director reviewed and revised the policy and procedure titled Preventing food borne illness: Food Handling, Storage, temperature record, Sanitation review, temperature and sanitizer log. On 7/17/23 the Director of Food Services provided education to the dietary department surrounding food storage, labeling and dating open items, and maintenance of cutting boards to prevent food born illness. 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 into place to monitor the continued effectiveness of the systemic change), The Director of Food Services will audit the kitchen for compliance with food storage, labeling, dating and sanitation, daily for 30 days, following five times a week for four weeks then monthly for two months. The results of the audit will be tracked and reviewed at the monthly Quality Assurance and Performance Improvement Committee for compliance; additional concerns will be reviewed and addressed as appropriate.	

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F 812	Continued From page 25 policy dated 2013, included...all exposed foods should be stored tightly covered... A review of the undated facility provided "Labeling and Dating" policy included...pies and cakes desserts made in house once product has been made in house, it will be marked with an expiration date of three days from when the product was made... A review of the facility provided "Equipment Maintenance" policy dated 2013, included...all food service equipment will be operated, maintained, serviced and cleaned according to manufacturer's directions. NJAC 8:39-17.2(g)	F 812	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 Food Services will be responsible for sustained compliance on or before 8/30 /23.	
F 880 SS=D	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 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	F 880		8/15/23

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F 880	Continued From page 26 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) 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 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.	F 880		

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F 880	Continued From page 27 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 review of pertinent facility documentation, it was determined that the facility failed to ensure their infection control policies were followed and maintained for water management to minimize the risk of legionella and other opportunistic pathogens in building water systems. This deficient practice had the potential to affect all 42 residents and was evidenced by the following: On 7/13/23 at 9:47 AM, the surveyor interviewed the Director of Facilities (DOF) who stated that he was not sure how often the facility tested the water for legionella (bacteria that can cause a serious type of pneumonia), that the facility had a scheduled testing in August. The DOF stated he was not aware when legionella testing was last done in the facility and would reach out to the Licensed Nursing Home Administrator (LNHA) in order to obtain that information. On 7/13/23 at 2:00 PM, the survey team met with the LNHA, Director of Nursing (DON) and Infection Preventionist/Assistant Director of Nursing (IP/ADON) and requested further information regarding the facility's water management program for legionella including a copy of the policy and any testing completed if applicable.	F 880	F880 SS=D Infection Prevention & Control Personnel CFR(s): 483.80 (a)(1)(2)(4)€(f) It is the practice of Laurel Circle to establish and maintain an infection program 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified as affected by the deficient practice. 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. Legionella testing for the community was conducted by the Administrator on 7/18/23. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and, On 07/21/2023 the administrator provided	

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F 880	Continued From page 28 On 7/14/23 at 9:35 AM, the LNHA in the presence of the DON and IP/ADON, provided the survey team with a copy of the facility's undated water management program, and confirmed that it was facility policy to test annually for legionella. The LNHA stated that he was unable to locate any pervious water testing for legionella; that he did not know where the previous Director of Facilities stored the documentation. At this time, the IP/ADON informed the survey team it was important to test the water for legionella because any bacteria in the water could be widespread and could cause gastrointestinal upset. The ADON/IP stated he had spoken to the Medical Director who stated the facility would conduct additional legionella testing if the residents were symptomatic. A review of the undated facility provided "Legionella Water Management Program" policy included...our facility is committed to the prevention, detection and control of water-borne contaminants, including legionella ...the purposes of the water management program are to identify areas in the water system where legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's Disease...the water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE recommendations for developing a legionella water management program...the Water Management Program will be reviewed at least once a year ... A review of the Centers for Disease Control and Prevention (CDC) "Water Management in Healthcare Facilities" dated last reviewed March 25, 2021, included the CDC encourages healthcare facilities included in the scope of	F 880	education to the Director of Facilities on policy revisions and role responsibilities. The Director of Facilities has scheduled legionella testing quarterly for the year 2023 and annually starting 2024. The Director of Facilities or designee will participate in the legionella testing and will record the results accordingly. 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 into place to monitor the continued effectiveness of the systemic change), The Health Center Administrator will do audits to ensure schedule for legionella reporting is complete per community policy monthly for three months then annually for the year 2024.. Ongoing compliance with this corrective action will be monitored through the monthly community Quality Assurance and Performance Improvement Program; additional concerns will be reviewed and addressed as appropriate. 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 Facilities will be responsible for sustained compliance on or before 08/15/2023.	

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F 880	Continued From page 29 ASHRAE Standard 188 (Section 5.2) to develop and implement comprehensive water management programs. Water management programs can help reduce the risk of legionella growth and transmission. Water management programs should therefore be monitored for their efficacy in reducing the risk for a variety of pathogens.	F 880		
F 947 SS=D	NJAC 8:39-19.1; 19.4 Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent	F 947	F947 SS=D Required In-Service Training	8/31/23

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F 947	Continued From page 30 facility documents, it was determined that the facility failed to maintain an effective tracking system to ensure that Certified Nursing Aides (CNA) received twelve hours of mandatory in-service training. This was identified for 4 of 5 CNA files reviewed for in-service education training (CNA #1, #3, #4, and #5) and was evidenced by the following: On 7/12/23 at 2:10 PM, the surveyor requested from the Director of Nursing to provide all education from 2022 for five randomly selected CNAs (CNA #1; #2; #3; #4; and #5). On 7/13/23 at 9:05 AM, the Licensed Nursing Home Administrator (LNHA) provided the survey team with education for the five selected CNAs with education dates which included both 2022 and 2023. At this time, the surveyor requested again the education provided in 2022. On 7/13/23 at 12:03 PM, the surveyor reviewed the 2022 education and in-service training provided by the facility. Review of the documents revealed the following: CNA #1 with a date of hire of [redacted], received [redacted] education hours for 2022, which included infection control and LGBTQ+ trainings. CNA #2 with a date of hire of [redacted], received [redacted] education hours for 2022. CNA #3 with a date of hire of [redacted], received [redacted] education hours for 2022, which included infection control, Health Insurance Portability and Accountability Act (HIPPA) Basics, Elder Justice Act, and LGBTQ+ trainings.	F 947	for Nurse Aides CFR(s): 483.95(1)-(4) It is the practice of Laurel Circle to ensure sufficient continuing competence of nurse aides that is no less then 12 hours per year. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified as affected by the deficient practice. 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. The Assistant Director of Nursing completed an audit of all CNA annual education on 7/25/23; an education fair will be initiated by the Assistant Director of Nursing on 8/1/23 to ensure all nurse□s aides meet the 12 hour minimum training requirement to be completed by 8/30/23 What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and, On 7/14/23 the Director of Nursing provided education to the Assistant Director of Nursing on the communities In-Service Training program policy and role responsibilities. On 7/14/23 the community□s annual Nurse Aide training plan was reviewed and revised by Administrator and Medical Director. The Assisted Director of Nursing will schedule and ensure completion of all	

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F 947	Continued From page 31 CNA #4 with a date of hire of [redacted], received [redacted] education hours for 2022, which included LGBTQ+ training only. CNA #5 with a date of hire of [redacted], received [redacted] education hours for 2022, which included infection control, abuse and neglect, [redacted], and LGBTQ trainings. On 7/13/23 at 12:51 PM, the DON stated during an office move last year, the Assistant Director of Nursing/Infection Preventionist (ADON/IP) was also the staff educator, misplaced a box that contained staff education from 2022. On 7/14/23 at 8:51 AM, the surveyor interviewed the ADON/IP who confirmed he was the staff educator as well with the responsibility to ensure all staff were in-serviced. The ADON/IP stated staff were mandated twelve hours of education with mandatory topics which included abuse and neglect, HIPPA, emergency preparedness, dementia care, and infection control. The ADON/IP stated he was conducting in-services on paper and then inputting the information into the computer in-service training program for 2022, but lost the binder during renovations before he finished inputting the in-services into the system. This year he was just putting all the in-services directly into the computer in-service education system, and "started this year to catch-up" on missing mandatory trainings. On 7/15/23 at 9:34 AM, the LNHA in the presence of the DON, ADON/IP, and survey team stated there had been no allegations of abuse made towards any of the five CNAs missing education hours. At this time, the ADON/IP confirmed there were no additional education hours that could be	F 947	annual education for CNA□s identified in the community wide audit on or before 8/30/23 The community will schedule ongoing continued education for nurses aides to be completed annually over 12 months. The Assistant Director of Nursing will log completion of education. 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 into place to monitor the continued effectiveness of the systemic change), The Director of Nursing or designee shall perform audits of up to ten employee files for completion of annual education monthly for three months. Results of the audits will be reviewed during the community's monthly Quality Assurance and Performance Improvement committee for completion and compliance; additional concerns will be reviewed and addressed as appropriate. 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 sustained compliance on or before 8/31/23	

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F 947	Continued From page 32 provided for the five CNAs for 2022; that all CNAs should have a minimum of twelve hours of education yearly which included mandatory topics. A review of the facility provided "In-Service Training Program, Nurse Aide" policy dated revised October 2017, included... annual in-services must:..be no less than twelve hours per employment year; address any weakness as determined by nurse aide performance reviews; include training that addresses the care of residents with cognitive impairment; and include training in dementia management... NJAC 8:39-43.17(b)	F 947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62215	A. BUILDING: _____ B. WING _____	C 07/14/2023

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

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S 000	Initial Comments NJ Compliant #: 163467 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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: NJ Compliant #: 163467 Based on interview and review of pertinent facility documents, it was determined that the facility failed to notify the Clearing House Coordinator for a Certified Nursing Assistant (CNA) who was terminated after professional misconduct with a resident (Resident #204) as mandated by the State of New Jersey. This deficient practice was identified for 1 of 4 residents reviewed for abuse, and the findings were as follows: Reference: New Jersey Administrative Code Title 13 Law and Public Safety Chapter 45E Health Care Professional Reporting Responsibility.	S 560	S560 8:39-5.1 (a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. It is the practice of Laurel Circle to comply with federal, state, and local laws, rules and regulations. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #204 was identified as affected by the deficient practice. Clearing House	7/31/23

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

Electronically Signed | 07/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	62215	A. BUILDING: _____ B. WING _____	C 07/14/2023

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

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S 560	Continued From page 1 Subchapter 3: 13:45E-3.1 Notification to the Clearing House Coordinator by a Health Care Entity a) Except as provided in (c) below, a health care entity shall file a report with the Clearing House Coordinator concerning a health care professional who is employed by, under contract to render professional services to, has clinical privileges granted by that health care entity, or who provides such services pursuant to an agreement with a health care services firm or staffing registry if: 1) For reasons relating to health care professional's impairment, incompetency or professional misconduct, which incompetency or professional misconduct relates adversely to patient care or safety, the health care entity: i) Summarily or temporarily revokes or suspends or permanently reduces, suspends or revokes the health care professional's full or partial clinical privileges or practice; ii) Removes the health care professional from the list of eligible employees of health services firm or staffing registry; iii) Discharges the health care professional from the staff of the health care entity; or iv) Terminates or rescinds a contract with the health care professional to render professional services: On 7/12/23 at 9:57 AM, the surveyor reviewed the closed medical record for Resident #204.	S 560	Coordinator was informed on 07/12/2023. The identified CNA's employment was terminated for professional misconduct. 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. On 07/12/2023 it was identified that Clearing House Coordinator was not informed regarding a CNA whose employment was terminated for professional misconduct. On 07/12/2023 The Health Center Administrator provided education to the Director of Nursing and Director of Human resources regarding reporting to appropriate agencies. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and, On 7/21/2023 the Health Center Administrator and Medical Director reviewed and revised the policy and procedure titled Abuse prevention Program and reviewed it with the Director of Nursing and Director of Human Resources. Any employees whose employment is terminated secondary to unprofessional behavior/misconduct, will be reported to the appropriate agencies including federal, state, local and Clearing house coordinator within 24 hours of termination. The Director of Humam resources will conduct weekly audits of all employees terminated secondary to unprofessional behavior/conduct to ensure appropriate agencies including federal , state , local	

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S 560	Continued From page 2 A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility in Ex Order 26. 4B1 with diagnoses that included Ex Order 26. 4B1 [redacted]. A review of the admission Minimum Data Set (MDS), an assessment tool dated [redacted] reflected a Ex Order 26. 4B1 [redacted] score of [redacted] out of 15, which indicated Ex Order 26. 4B1 [redacted]. A review of a Clinical Note dated 4/14/23 at 4:58 PM, indicated that the Nursing Supervisor and the Licensed Nursing Home Administrator (LNHA) addressed the resident's concern about the resident's morning CNA. A review of the facility's reportable event investigation submitted to the New Jersey Department of Health (NJDOH) on 4/14/23 at 9:15 AM, indicated the resident's (Resident #204) concern was substantiated, and the CNA was no longer working at the facility. On 7/12/23 at 9:45 AM, the surveyor interviewed the LNHA who stated he reported the allegation to the NJDOH, the Ombudsman, and completed an investigation with statements from residents and staff. The LNHA stated that after the investigation, he determined that the Ex Order 26. 4B1 was substantiated, and the CNA was terminated since the investigation revealed that the CNA did not listen to the resident's request to stop performing care after the resident asked several times. The LNHA stated that the behavior was unacceptable,	S 560	and clearing house have been notified in compliance with community policy. 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 into place to monitor the continued effectiveness of the systemic change), Five terminated employee files will be reviewed/audited by The Director of Human Resources, five times a week for four weeks to ensure compliance then monthly for six months. Results of the audits of all termed employees will be reviewed during the community's monthly Quality Assurance and Performance Improvement committee meeting for compliance for the next 6 meetings; additional concerns will be reviewed and addressed as appropriate. 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 Administrator, Director of Nursing and Director of Human Resources will ensure compliance by 08/30/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 3 and that the CNA should have stopped care immediately after the resident's first request, and not after several requests. The LHNA stated that he terminated the CNA's employment for professional misconduct, because he did not want the CNA to work at the facility anymore to ensure this incident would not occur again. The LNHA stated that he did not notify the Clearing House Coordinator since he was unaware of the requirement. On 7/12/23 at 11:15 AM, the LNHA acknowledged to the surveyor that the CNA should have been reported to the Clearing House Coordinator. A review of the facility's "Abuse Prevention Program" policy dated revised November 2017, did not include contacting the Clearing House Coordinator. NJAC 8:39-5.1(a)	S 560		
S2315	8:39-31.6(i)(1-2) Mandatory Physical Environment (i) The administrator shall serve as, or appoint, a disaster planner for the facility. 1. The disaster planner shall meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan; or if county or municipal officials are unavailable for this purpose, the facility shall notify the State Office of Emergency Management. 2. While developing the facility's evacuation	S2315		8/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S2315	Continued From page 4 plan, the disaster planner shall coordinate with the facility or facilities designated to receive relocated residents. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to meet with municipal and county emergency management officials annually to review and update the emergency evacuation plan. This deficient practice was evidenced by the following: On 7/13/23 at 9:00 AM, the surveyor began reviewing the facility provided Emergency Preparedness Plan (EPP). The surveyor was unable to locate current documentation that the municipal and county emergency management officials reviewed the emergency evacuation plan annually. On 7/13/23 at 10:10 AM, the surveyor interviewed the Director of Facilities (DOF) who was identified as responsible for the facility's EPP. The surveyor inquired if the EPP had been reviewed by the municipal and county emergency management officials. The DOF stated that he started the position about a year ago, and would have to check if an email was sent by the previous Director of Facilities. The DOF advised that the Licensed Nursing Home Administrator (LNHA) would have this information.	S2315	S2315 8:39-5.1 (a) Mandatory Physical Environment (b) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. It is the practice of Laurel Circle to 1. meet with the county and municipal emergency management coordinators at least once a year to review and update the written comprehensive plan: or if county or municipal officials are unavailable for the purpose, the facility shall notify the state office of emergency management. 2. While developing the facility□s evacuation plan, the disaster planner shall coordinate with the facility or facilities designated to receive relocated residents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified as affected by the deficient practice. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S2315	Continued From page 5 On 7/14/23 at 9:34 AM, the LNHA in the presence of the survey team, confirmed that he and the DOF were responsible for the maintenance of the EPP, and that the facility had no documentation that the municipal and county emergency management officials reviewed and approved of their EPP plan. When asked if the EPP should be submitted yearly for review and approval, the LNHA confirmed yes. NJAC 8:39-31.2(e); 31.6(i)	S2315	All residents have the potential to be affected by this deficient practice. On 07/14/2023 it was identified that the facility had no documentation that the municipal and county emergency management officials reviewed and approved the EPP plan. On 7/14/2023 Administrator provided education to the Director of Facilities regarding having the local municipal and county emergency management officials review and approve the EPP plan. EPP plan will be reviewed by the county or municipal officials by 08/15/2023. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and, On 7/21/2023 the Health Center Administrator reviewed with the Director of Facilities, policy and procedure for emergency management, including having the local, municipal and county emergency management officials review and approve the EPP plan. The Director of Facilities will maintain a communication log of all meetings with the local, municipal and county emergency management officials. An audit of five records of communication with the local municipal and county emergency management will be completed monthly for three months, then once every year and submitted to the Administrator for review. Outcomes of the EPP plan review by the county municipal officials will be discussed and followed by the Health Center Administrator. How the facility will monitor its corrective action(s) to ensure that the deficient	

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S2315	Continued From page 6	S2315	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), Results of five of the audits of records of communication with the local municipal and county emergency management will be submitted to the monthly community Quality Assurance and Performance Improvement committee monthly for three months then once every year for compliance. additional concerns will be reviewed and addressed as appropriate. 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 Administrator, and Director of Facilities will be responsible for sustained compliance on or before 08/15/2023.	

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	9/12/2023 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 F0607	Correction	ID Prefix F0677	Correction	ID Prefix F0730	Correction
Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.24(a)(2)	Completed	Reg. # 483.35(d)(7)	Completed
LSC	08/31/2023	LSC	08/31/2023	LSC	08/31/2023
ID Prefix F0802	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.60(a)(3)(b)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	08/31/2023	LSC	08/30/2023	LSC	08/15/2023
ID Prefix F0947	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.95(g)(1)-(4)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/31/2023	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?
7/14/2023	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315445		9/12/2023

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0607 Reg. # 483.12(b)(1)-(5)(ii)(iii) LSC	Correction Completed 08/31/2023	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
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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
7/14/2023

☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
62215 Y1	A. Building B. Wing Y2	9/12/2023 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 07/31/2023	ID Prefix S2315 Reg. # 8:39-31.6(i)(1-2) LSC	Correction Completed 08/15/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 7/14/2023	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
62215 Y1	A. Building B. Wing Y2	9/12/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
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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 7/14/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315445	A. BUILDING **01** B. WING _____	**07/14/2023**

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

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K 000	INITIAL COMMENTS The nursing home building construction was stated to be in the 90s with no current major renovations or noted additions. It is a two story building Type II (222) protected construction and is fully sprinklered. The outside 300 KW diesel generator W/550 gallon fuel tank does approximately 80% of the Health Care building. The Health Care Center observed is located on the 2nd floor and divided into 4-wings: East wing resident rooms: 620-629 West wing resident rooms: 639-665 North wing resident rooms: 630-638 South wing resident rooms: 601-608 W/Kitchen area The 2nd floor (Health Care) is divided into 7-smoke zones. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility has 64 certified beds. At the time of the survey the census was 42. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING	K 311		7/28/23

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

Electronically Signed | 07/31/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315445	A. BUILDING **01** B. WING _____	**07/14/2023**

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
K 311	Continued From page 1 Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 7/10/23, in the presence of the Plant Operations Director (POD), it was determined that the facility failed to maintain exit stairways free from storage to obstruct egress. This deficient practice was identified for 1 of 4 exit/egress stairwells, and was evidenced by the following: On 7/10/23 at 11:09 AM, the surveyor observed in the H-4 stairwell lower level, where the exit/egress door was located that three (3) food trucks were being stored on the right-side of the stairs; then by the right-side of the door to the public way: 5-full size doors, approximately (14) black three-feet (3') pipe, orange cone, green plastic bin filled with white balls, and a small silver and black hand truck were being stored. The POD confirmed the findings and stated the above items should not be stored in the stairway enclosure; it obstructed the egress. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 7/10/23. NFPA A.7.1.3.2.3- This provision prohibits the use	K 311	K311 SS= Vertical Openings - Enclosure CFR(s): NFPA 101 It is the practice of Laurel Circle to ensure all stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings are free of obstruction and clear for egress in accordance with NFPA A.7.1.3.2.3 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified as affected by the deficient practice. 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. All stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings have been cleared of storage, and/ or obstruction of egress. What measures will be put into place or systemic changes made to ensure that	

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K 311	Continued From page 2 of exit enclosures for storage or for installation of equipment not necessary for safety. Occupancy is prohibited other than for egress, refuge, and access. The intent is that the exit enclosure essentially be "sterile" with respect with fire safety hazards. NJAC 8:39-31.2(e)	K 311	the deficient practice does not recur; and, On 07/10/23 the Director of Facilities educated the Dietary Department/Maintenance Department of the importance of the provision that prohibits the use of exit enclosures for storage or for installation of equipment not necessary for safety. On 07/10/23 All stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings have been cleared of storage, and/ or obstruction of egress. The Director of Facilities/ Designee will conduct daily rounds to ensure all stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings have been cleared of storage, and/ or obstruction of egress 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 into place to monitor the continued effectiveness of the systemic change), An audit to check all stairways will be conducted 4 times a week x 1 month then monthly for 12 months for storage and obstruction of egress during maintenance rounds. Results of four of the audits will be submitted to the monthly Quality Assurance and Improvement Committee for review ; additional concerns will be reviewed and addressed as appropriate. 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.	

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K 311	Continued From page 3	K 311	The Director of Facilities will be responsible for compliance on or before 07/28/23.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 7/10/23, in the presence of the Plant Operations Director (POD), the facility failed to ensure: a.) that their fire alarm system documentation total initiating devices tallied correctly in accordance with the requirements of NFPA 70 and 72., and b.) smoke detection sensitivity testing were completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. The deficient practice was identified for 3 of 3 inspection reports and was evidenced by the following: 1. On 7/10/23 at 10:45 AM, the surveyor reviewed all related fire alarm documentation provided by the POD from the fire alarm vendor dated: 2/12/21, 2/7/22, and 2/10/23. The documents indicated that the total items of smoke detector devices were different on each inspection report: 2/12/21 - smoke detectors, total items 137	K 345	K345 SS=F Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 It is the practice of Laurel Circle to test and maintain all fire alarm systems in accordance with an approved program complying with the requirements of NFPA 70,National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified as affected by the deficient practice. 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.	7/28/23

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K 345	Continued From page 4 2/7/22 - smoke detectors, total items 192 2/10/23 - smoke detectors, total items 171 The POD confirmed the findings during document review and stated the initiating devices (smoke detectors), did not tally correctly on each report. 2. On 7/10/23 at 10:45 AM, the surveyor reviewed all related fire alarm documentation provided by the POD from the fire alarm vendor to determine if the sensitivity test was performed. The reports were dated: 2/12/21, 2/7/22, and 2/10/23. The reports provided did not indicate any information on the testing of the smoke detectors for sensitivity or when the last sensitivity test was conducted. An interview was conducted with the POD during document review who stated he was not sure if the required sensitivity test for the facility smoke detectors were performed. The POD further stated he would contact the facility fire alarm vendor to see if sensitivity report was performed. The POD then provided a document indicating that a sensitivity inspection will be conducted on the 20th, no month or year was identified on the document for the appointment date. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code Exit conference on 7/10/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345	Fire alarm vendors will ensure that all fire alarm system documentation total initiating devices will be tallied correctly in accordance with the requirements of NFPA 70 and 72. The Director of Facilities will have all future smoke detection sensitivity testing completed of the facility smoke detectors in accordance with NFPA 72(2010 edition) section 14.4.5.3.2. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and, On 07/10/23 the Director of Facilities contacted the fire alarm vendor and requested updated fire alarm documentation. The fire alarm vendor provided the Director of Facilities with correct count of initiated facility smoke detectors related to healthcare community, which is 161. On 07/20/23 fire alarm vendor completed required sensitivity test for the facility smoke detectors. On 07/20/23 The Director of Facilities educated the Maintenance Department on policy and procedure for Smoke detector sensitivity testing, Fire alarms and Fire Alarm system documentation. 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 into place to monitor the continued effectiveness of the systemic change), The Plant Director of Operations or designee shall audit four fire alarm vendor reports to ensure all future fire alarm initiating devices (smoke detectors) are	

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K 345	Continued From page 5	K 345	tallied correctly in accordance with the requirements of NFPA 70 and 72. Results of four audits of completed required vendor sensitivity test for the facility smoke detectors will be submitted monthly for three months then annually to the monthly Quality Assurance and Performance Improvement committee. For review, additional concerns will be reviewed and addressed as appropriate. 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 Facilities is responsible for compliance on or before 07/28/23.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K 353		7/28/23

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K 353	Continued From page 6 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview conducted on 7/10/23, it was determined that the facility failed to ensure that their automatic sprinkler system was inspected/tested at the required fifth-year interval according to NFPA 25. This deficient practice was identified for 3 of 3 fire sprinkler systems (2-wet and 1-dry) observed in the facility, and was evidenced by the following: On 7/10/23 at 10:30 AM, the surveyor reviewed the facility's annual automatic sprinkler system inspection report's for the entire year dated: 9/20/22, 12/8/22, 3/17/23, and 6/15/23. The reports did not indicate when the last fifth-year internal obstruction investigation of the pipe was completed. On 7/10/23 at 11:45 AM, the surveyor interviewed the POD who stated that he was not sure if the fifth-year internal pipe obstruction inspection was conducted, but communication with the facility fire sprinkler vendor revealed that the fifth-year test of the internal pipe was to be scheduled for 7/20/23. The provided documentation did not indicate when the last five-year was conducted. The Licensed Nursing Home Administrator was informed of the finding at the Life Safety Code exit conference on 7/10/23. NFPA (National Fire Protection Association) 25 requires an internal inspection of the fire sprinkler system piping every 5 years, this is to be conducted to inspect for the "presence of foreign organic material" foreign materials can cause obstructions to pipe and sprinklers.	K 353	K353 SS=F Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 It is the practice of Laurel Circle to ensure all automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified as affected by the deficient practice. 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. Sprinkler system vendor will test 3 of 3 fire sprinkler systems (2 wet 1 dry) 1x every five (5) years in accordance with NFPA 25 requirements. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and, On 07/20/23 Sprinkler system vendor completed fifth year interval testing of all sprinkler systems. (2 wet 1 dry) On 7/20/23. Director of facilities provided education with all Maintenance personnel to ensure sprinklers and standpipe	

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K 353	Continued From page 7 NFPA 13, 25 NJAC 8:39-31.2(e)	K 353	systems are tested and or inspected per community policy. Records of system design, maintenance, inspection, and testing will be maintained in a secure location and readily available. 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 into place to monitor the continued effectiveness of the systemic change), The Director of facilities or designee shall review records of fifth year interval sprinkler testing and maintenance reports submitted by sprinkler vendor annually, for two years for tracking then once every five years to ensure compliance with community policy. The Director of Facilities/ designee will conduct five monthly audits of the sprinkler testing system to ensure compliance. Results of four audits of vendor completed testing and maintenance will be submitted to the Quality Assurance and Performance Improvement committee annually for two years and then once every 5 years. Additional concerns will be reviewed and addressed as appropriate. 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 Facilities will be responsible for compliance on or before 07/28/23.	
K 918 SS=F	Electrical Systems - Essential Electric Syste	K 918		9/13/23

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K 918	Continued From page 8 CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 7/10/23,	K 918	K918 SS=F Electrical Systems -	

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K 918	Continued From page 9 in the presence of the Plant Operations Director (POD), it was determined that the facility failed to ensure a remote manual stop station for one of one outside generators (300 KW), providing emergency power to approximately 80% of Health Care facility, was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced by the following: On 7/10/23 at 1:05 PM, the surveyor and POD observed the exterior 300 KW (kilowatt) diesel generator. The observation indicated that there was no remote manual stop station observed outside the area of the generator location. An interview was conducted during the time of the observation with the POD, who stated and confirmed that the exterior generator did not have a remote manual stop station to prevent inadvertent or unintentional operation that was located outside the area of the enclosure housing the prime mover for the current generator in service. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 7/10/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	Essential Electric System Maintenance and Testing CFR(s): NFPA 101 It is the practice of Laurel Circle to test and maintain generator or other alternate power source and associated equipment is capable of supplying service within 10 second performed in accordance with NFPA 110. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified as affected by the deficient practice. 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. Generator vendors will be contacted to quote for installation of remote manual stop station for one outside generator (300 KW) providing emergency power to approximately 80% of Health Care facility. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and, On 07/20/23 the Director of facilities contacted generator vendor and requested quote for installation of one remote stop for a 300kw generator. Generator vendor will be on site on 08/21/23 to quote for installation of one remote stop for 300kw generator. 7/20/23. Director of facilities was educated by the Health Care Administrator, on Policy and procedure on	

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K 918	Continued From page 10	K 918	Maintenance of generator or other power source and associated equipment. 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 into place to monitor the continued effectiveness of the systemic change), The Director of facilities or designee shall provide quote of remote stop for one 300kw generator to Administrator once received from generator vendor. Remote stop will be installed once/if qualifications are met, reviewed, and accepted by LC Healthcare facility and designated qualified electrical inspector. Appropriate township licenses have been applied for to the township. Generator switch work is to start on 9/11/23 with an expected finish date of 9/13/2023 The Dirrctor of facilities will conduct one audit to ensure proper functioning of generator weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly Quality Assurance and Performance Improvement committee, additional concerns will be reviewed and addressed as appropriate. 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 Facilities will be responsible for compliance on or before 09/13/23.	

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 01 - MAIN BUILDING 01 B. Wing Y2	9/14/2023 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0311	07/28/2023	LSC K0345	07/28/2023	LSC K0353	07/28/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	09/13/2023	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	
7/14/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO