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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ148045, NJ150847, NJ154391, NJ156388, and NJ156804 Census: 47 Sample Size: 13 The facility is not compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. Survey date: 01/20/2023 - 01/22/2023	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		2/17/23

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

Electronically Signed | 02/14/2023

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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint #NJ156388 Based on interviews, review of the facility policy, and record review, the facility failed to notify the responsible party (RP) of incidents of a resident [redacted], and transfers to the hospital for 1 (Resident #1) of 3 residents sampled for notification of changes. Findings included: A review of the facility's policy titled, "Change in a Resident's Condition or Status," revised May	F 580	F580 SS=D Notify of Changes (Injury/Decline/Room, etc.)CFR(s): 483.10(g)(14)(i)-(iv)(15) It is the practice of Laurel Circle to notify the resident, physician and responsible party when a resident experiences a change in condition. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident number one no longer resides at	

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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 2018 indicated, "Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when: a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. There is significant change in the resident's physical, mental, or psychosocial status; c. There is a need to change the resident's room assignment; d. A decision has been made to discharge the resident from the facility; and/or e; It is necessary to transfer the resident to a hospital/treatment center." A review of the "Face Sheet" indicated the facility admitted Resident #1 with diagnoses that included [redacted]. The Face Sheet also identified the RP as the person that had all responsibility for Resident #1. There was only one RP listed on the Face Sheet. A review of the quarterly Minimum Data Set (MDS) for Resident #1, dated [redacted] indicated the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident was [redacted]. No behaviors were identified on the MDS. The MDS indicated Resident #1 required supervision for locomotion on the unit and eating, limited assistance for locomotion off the unit, and extensive assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #1 had no [redacted] disorders identified on the MDS. A review of the "Care Plan" for Resident #1, revised on [redacted], indicated the resident had	F 580	the community. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this deficient practice; an audit of all active residents was conducted to identify change in condition and no like residents were identified. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and, On January 23, 2023, all licensed professionals were educated by the Director of Nursing on the facility Policy and Procedure of Change in a resident□s condition or Status. Newly hired licensed professionals will be in serviced by the Educator or designee on promptly notifying resident, attending physician and representative of changes in the residents resident□s condition or Status. The Unit manager/Supervisors or designee will monitor and document all residents with change in condition or status in the clinical record. The unit manager, supervisor or designee will ensure notification to the resident, physician and resident representative is completed timely and documented in the clinical record. 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),	

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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 a problem area of [redacted] and had disorders that manifested by [redacted]. The care plan indicated the resident [redacted] and had [redacted]. The care plan further indicated on [redacted] the resident had approached another resident and slapped the resident. The interventions included assessing the potential causes for deterioration to include lack of [redacted], and/or [redacted]. Review of the "Clinical Notes," dated [redacted] at 2:12 AM, indicated at 4:30 PM the unit clerk reported to the nurse that Resident #1 was sitting at the unit secretary's desk and approached another resident and slapped the resident's [redacted] with an [redacted]. The nurse documented Resident #1's RP would be notified of the incident the following morning. At 11:38 AM on [redacted], the clinical notes indicated the resident had no further behavioral issues. Review of the clinical notes revealed there were no further notes for Resident #1 until [redacted] There was no documentation that Resident #1's RP had been notified of the [redacted] incident involving Resident #1. A review of the "Clinical Notes," dated [redacted] at 3:48 PM, indicated Resident #1 received every half hour checks, where the resident was observed and redirected as needed when the resident attempted to go in other residents' rooms. There was no documentation that indicated the RP was made aware of the [redacted] incident. The review of the "Clinical Notes," dated [redacted] at 4:57 PM, indicated Resident #1 continued to attempt to enter other residents'	F 580	The Director of Nursing or designee shall perform random audits of up to five patients with change in condition or status weekly for four weeks then monthly for 6 months. Audits 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. 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 February 17th ,2023.	

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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4	F 580		

rooms and refused vital signs. There was no documentation that Resident #1's RP was made aware of the [redacted] or [redacted].

A review of the "New Jersey Universal Transfer Form," dated [redacted], with no time entered, revealed Resident #1 had two episodes of [redacted]. The form had the RP's name and telephone number listed, but there was no indication the RP had been notified of the transfer.

A review of the "Clinical Notes," dated [redacted] at 10:08 PM indicated Resident #1 had exhibited aggressive behavior toward another resident during the day shift. The note indicated both the resident's [redacted] and the primary care physician were notified and ordered Resident #1 to be transferred to the hospital emergency department for evaluation. There was no documentation Resident #1's RP was notified of the resident's transfer to the hospital.

Registered Nurse (RN) #4 was interviewed on 01/21/2023 at 3:05 PM. The nurse stated she notified the physician and RP for a resident that refused care, onset of behaviors, when medications changed, a change in condition, and when a resident was transferred to the hospital.

RN #6 was interviewed on 01/21/2023 at 3:57 PM. The nurse stated family members were notified when a resident's medications were changed, physical status changed, and before being sent to the hospital. The nurse stated Resident #1 was transferred to the hospital on [redacted] due to the resident's behavior becoming unmanageable. RN #6 stated he worked the day the resident was transferred, but

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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5	F 580		

he had not called Resident #1's RP. The nurse stated that prior to his arrival, the Director of Nursing (DON) and Resident #1's RP had a conversation, and the RP knew the resident was being sent to the hospital.

RN #8 was interviewed on 01/21/2023 at 5:05 PM. RN #8 stated she provided notification to the MD and the RP when a resident was transferred to the hospital, after falls, development of wounds, skin tears, any change in condition, and changes in medication.

Resident #1's RP was interviewed by phone on 01/22/2023 at 12:20 PM. The RP stated the resident had been sent to the hospital in [redacted] for behaviors and to receive a [redacted] evaluation. The RP stated he/she had no notification about Resident #1's transfer to the hospital and only found out the resident had been discharged when the hospital called to let him/her know Resident #1 would be returning to the facility. The RP stated he/she called the DON and asked why he/she had not received notification of the transfer and asked that the DON alert him/her when the resident arrived back in the facility. Resident #1's RP stated he/she heard nothing more from the facility. The RP stated at 9:30 PM on [redacted], he/she called the facility to see if the resident had arrived and was told by RN #10 that Resident #1 had arrived at the facility but had immediately been sent back to the hospital due to arriving in the facility in [redacted].

RN #10 was interviewed on 01/22/2023 at 1:18 PM. RN #10 stated she had called Resident #1's RP on [redacted] when the resident was returned to the hospital due to the [redacted] the resident was wearing when the resident arrived at

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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6 the facility. RN #10 added there was no reason for the lack of documentation that described the transfer or the RP's notification and there was no reason why she had not documented. The DON was interviewed on 01/22/2023 at 2:42 PM. The DON stated if a resident was transferred to the hospital or if the resident was involved in an incident that was reported to a state agency, she expected the family or RP to be immediately notified. The DON stated it was the responsibility of the assigned nurse or the nurse supervisor to notify the family. The DON stated she reviewed Resident #1's clinical notes for the [redacted] incident and verified the nurse had not called the family and had written the family would be contacted the next day. She verified there was no documentation of family notification on [redacted] or [redacted]. The DON reviewed Resident #1's medical record and confirmed she could find no documentation the resident's representative had been notified when the resident was sent to the hospital on [redacted] and no documentation the resident's representative was notified prior to the facility sending the resident back to the hospital on [redacted] On 01/23/2023 at 5:50 PM, the Administrator was interviewed and stated nurses were expected to notify family members or responsible parties about falls, medication changes, transfers to the hospital, issues that required state reports, and any change in a resident's condition. The Administrator stated Resident #1's RP was notified before the resident was transferred to the hospital, but the Administrator was unaware who notified the RP and said without documentation he did not have "a leg to stand on."	F 580		

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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7 The telephone number for the nurse that documented the [redacted] note was requested multiple times but was not provided by the facility.	F 580		
F 880 SS=D	New Jersey Administrative Code § 8:39-5.1(a) 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 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	F 880		2/17/23

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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8 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. 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: Complaint #NJ154391 Based on interviews, record review, Centers for	F 880	F880 SS=D Infection Prevention and Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)483.80	

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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9 Disease Control and Prevention (CDC) guidelines, and facility policy review, the facility failed to maintain an infection prevention and control program to prevent the transmission of communicable diseases for 1 (Resident #1) of 4 residents reviewed for infection control. Resident #1 tested [redacted] for [redacted] on [redacted] and the facility failed to ensure isolation precautions were maintained for the resident. Findings included: The facility's policy, titled, "Considerations for Cohorting [redacted] Patients in Post-Acute Care Facilities," dated 02/25/2022, indicated, "Patient/resident management 1) [redacted] positive patients/residents (i.e., [redacted] care unit/area) These individuals consist of both symptomatic and asymptomatic patients/residents who test positive for [redacted], regardless of vaccination status. This also includes any new or re-admitted patients/residents known to be positive who have not met the criteria for discontinuation of transmission-based precautions. If feasible, care for [redacted] positive patients/residents on a separate closed unit. Patients/residents should be placed in the [redacted] care unit/area, regardless of symptoms, if they have confirmed [redacted] infection." A review of Centers for Disease Control and Prevention (CDC) guidelines, provided by the facility and described as the guidelines they were using, titled, "Considerations for [redacted] Care Units in Long-term Care Facilities," dated 05/13/2020, indicated, [redacted] care services, designed to meet the unique needs of residents with [redacted], are often provided in dedicated	F 880	It is the practice of Laurel Circle to 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident number one no longer resides at the community. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the alleged deficient practice. A review of all residents, including those with [redacted], was conducted and no like residents were identified. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and, All licensed professionals were in-serviced by the Director of Nursing, on January 22,2023, on [redacted] identification and management of ill residents to ensure staff follow standards of practice for [redacted] infection prevention and control measures. On January 25th 2023, all Licensed Professional staff were educated by the Infection Preventionist on strategies used for rapid identification and management of [redacted] infected residents in compliance with current	

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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 10 care units or wings of a facility. Infection prevention strategies to prevent the spread of [redacted] are especially challenging to implement in dedicated [redacted] where numerous residents with [redacted] resides together." A review of the "Face Sheet" indicated the facility admitted Resident #1 with diagnoses that included [redacted]. A review of the quarterly Minimum Data Set (MDS), dated [redacted], indicated Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident was [redacted]. No behaviors were identified on the MDS. The MDS indicated Resident #1 required supervision for locomotion on the unit and eating, limited assistance for locomotion off the unit, and required extensive assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #1 had no [redacted] disorders identified on the MDS. A review of the "Care Plan" for Resident #1, revised on [redacted], indicated Resident #1 was at risk for social isolation related to testing [redacted] for [redacted] and was at risk for behaviors. A review of a "Nursing Note," dated [redacted] at 4:49 PM, revealed Resident #1 was noted to have a [redacted] and [redacted] were [redacted] The doctor was asked to evaluate Resident #1 and a [redacted] test was conduct. The note indicated Resident #1 was [redacted] for [redacted]	F 880	recommendations from the Center for Disease Control and Prevention to prevent the transmission of [redacted] within the facility. All surveillance findings are reviewed by the Infection Preventionist or designee. The Infection Preventionist or designee will monitor and track all infections to ensure appropriate interventions are taken to mitigate risk and prevent the spread of [redacted]. The Infection Preventionist or designee with audit to ensure Licenses Nurses initiate isolation protocol timely for resident with suspected or confirmed cases of [redacted] Residents who are unable to adhere to isolation protocols will be reviewed immediately for further need for intervention. As outlined in the directed in-service training, the community will provide in-service training to appropriate staff with competency validated by the director of nursing, medical director or infection preventionist as follows: The Director of Nursing will ensure the Infection Preventionist, and topline staff complete the Nursing Home Infection Preventionist Training Corse: Module 1 – Infection Prevention and Control Program on or before 2/28/23. The Director of Nursing will ensure the Infection Preventionist, and topline staff complete the Nursing Home Infection Preventionist Training Corse: Module 4 – Infection Surveillance on or before 2/28/23. The Director of Nursing will ensure the	

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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 and isolation signs were immediately placed on the resident's door, and the resident was given a mask. The note further indicated Resident #1 could remain in their room for isolation as the resident always [redacted] the unit with their wheelchair. A review of the "Nursing Note," dated [redacted] at 11:00 PM, revealed Resident #1 was on isolation precautions but was [redacted] with isolation and staff would continue to re-educate the resident. The note indicated Resident #1 was receiving [redacted] (medication for [redacted]) every [redacted] hours. A review of the "Nursing Note," dated [redacted] at 4:24 PM, revealed Resident #1 was confused and [redacted] "all over the unit" in their wheelchair. The note indicated Resident #1 was asked repeatedly to adhere to isolation precautions but refused. A review of the "Nursing Note," dated [redacted] at 11:10 PM, revealed Resident #1 was in and out of their room and required redirection at all times. The note indicated Resident #1 was [redacted] with isolation. During an interview on 01/21/2023 at 9:30 AM, Certified Nursing Assistant (CNA) #1 revealed residents that were [redacted] were isolated from other residents, and the staff wore full personal protective equipment (PPE) when interacting or caring with the [redacted] resident. CNA #1 indicated there was an area of the facility for [redacted] residents that was at the end of the hallway away from other residents that were not [redacted] CNA #1 revealed Resident #1 had behaviors and was [redacted] at times. She	F 880	Infection Preventionist and topline staff complete the Nursing Home Infection Preventionist Training Corse: Module 5 – Outbreaks on or before 2/28/23. The Director of Nursing will ensure All staff including the Infection Preventionist and topline staff complete the Nursing Home Infection Preventionist Training Corse: Module 6A –Principles of Standard Precautions on or before 2/28/23. The Director of Nursing will ensure All staff including the Infection Preventionist and topline staff complete the Nursing Home Infection Preventionist Training Corse: Module 6B –Principles of Transmission Based Precautions on or before 2/28/23. The Director of Nursing will ensure frontline staff complete the CDC [redacted] Prevention messages for front line Long-Term care staff: Keep [redacted] Out! on or before 2/28/23. The Director of Nursing will ensure frontline staff complete the CDC [redacted] Prevention messages for front line Long-Term care staff: Closely Monitor Residents on or before 2/28/23. The Director of Nursing will ensure frontline staff complete the CDC [redacted] Prevention messages for front line Long-Term care staff: Use PPE Correctly for [redacted] on or before 2/28/23. RCA has been completed. 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	

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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 stated the resident would roam in and out of other rooms and required frequent monitoring. CNA #1 indicated that when Resident #1 had [redacted], it was difficult to keep the resident in their room and they had to be redirected often. CNA #1 indicated Resident #1 was encouraged to wear a mask, but the resident would take it off or wear it below their chin. During an interview on 01/21/2023 at 2:26 PM, CNA #3 revealed Resident #1 had [redacted] and often had to be redirected to go back to their room. During an interview on 01/21/2023 at 2:39 PM, Registered Nurse (RN) #4 revealed [redacted] residents were required to be isolated, and residents were tested as the regulation required but also anytime there were symptoms that developed like coughing or runny nose. RN #4 indicated Resident #1 had [redacted] in [redacted] and due to [redacted] they had to be redirected and put back in their room at times. During an interview on 01/21/2023 at 3:26 PM, Licensed Practical Nurse (LPN) #5, the infection control nurse, revealed any resident or staff member who became symptomatic for [redacted] was tested immediately. He stated new admissions were tested, and residents were also tested based on if there was an outbreak. LPN #5 revealed Resident #1 was the first resident who tested positive for [redacted] in the month of [redacted]. LPN #5 stated he attempted to contact trace to determine where Resident #1 obtained [redacted] but was unsuccessful, so all residents and staff were tested. LPN #5 indicated the residents were then tested every two to three	F 880	into place to monitor the continued effectiveness of the systemic change), The Director of Nursing /Infection Preventionist or designee will perform audits of isolation for newly identified resident with suspected or confirmed [redacted] daily for fourteen days, then weekly for four weeks then monthly for six months. Audits 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. 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 February 17th, 2023.	

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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13	F 880		

days. LPN #5 revealed that at that time, there was an entire hallway dedicated to [redacted] residents and there were eight rooms available. LPN #5 revealed Resident #1 was not placed in the [redacted] unit due to the resident's confusion and behaviors. Resident #1 was in a private room, and a sign was immediately placed on the resident's door with personal protective equipment (PPE) available. LPN #5 indicated Resident #1 did come out of their room at times, but it was not frequent and staff would put a mask on Resident #1 and redirect them back to their room. LPN #5 stated he did not witness Resident #1 going into other residents' rooms while the resident was [redacted] for [redacted] LPN #5 indicated Resident #1 had [redacted], and that was what triggered the staff to test Resident #1 for [redacted].

During an interview on 01/21/2023 at 3:48 PM, RN #6 revealed Resident #1 was always in the hallway or dining room. RN #6 stated Resident #1 also enjoyed sitting in the doorway of their room. RN #6 stated Resident #1 developed a mild occasional [redacted] so they were tested immediately for [redacted]. RN #6 indicated Resident #1 was placed in isolation in their private room. RN #6 indicated Resident #1 would have to be redirected to stay in their room anytime they would try to exit the room.

During an interview on 01/22/2023 at 2:38 PM, the Director of Nursing (DON) revealed Resident #1 was placed in isolation for [redacted] in the resident's room on [redacted]. The DON stated Resident #1 had [redacted] and [redacted] and due to their [redacted], they required redirection to wear a mask and to stay in their room. The DON did not recall Resident #1 going

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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14	F 880		

into other residents' rooms but would attempt to come in the hall and staff would redirect them back into their room.

During an interview on 01/22/2023 at 4:54 PM, LPN #5 revealed residents with [redacted] who obtained [redacted] would be isolated in the [redacted] unit, when possible, but if it was going to cause [redacted] to move the resident, they could stay in their own rooms where they were more comfortable. LPN #5 stated residents were asked to wear masks, and staff wore PPE when they went into the room. LPN #5 revealed when Resident #1 became [redacted], the LPN discussed it with the DON and the Administrator, and they determined that if Resident #1 was moved to the [redacted] unit it would increase their behaviors and not be good for the resident. LPN #5 indicated that sometimes they attempted to move [redacted] residents to the [redacted] unit and see if it worked, but in the case of Resident #1 they did not feel they should try to move the resident. LPN #5 indicated they followed the guidance from the CDC for residents in a [redacted] LPN #5 revealed Resident #1 was not living in a [redacted] or [redacted] unit and the facility did not have a [redacted] unit. LPN #5 reported there was not any documentation to support not moving Resident #1 to the [redacted] unit. LPN #5 revealed Resident #1 would attempt to exit their room, but staff would redirect the resident. Resident #1 would wear a mask at times, but often it was below their chin or nose.

During an interview on 01/22/2023 at 5:50 PM, the Administrator revealed the facility staff made the determination that when Resident #1 tested positive for [redacted] to keep the resident in their

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 01/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15 room for quality of life. The staff was very familiar with Resident #1 and did not feel it would be good for the resident to move. The Administrator revealed Resident #1's room was the [redacted] located near the nurses station at the beginning of the hallway, so when staff would notice Resident #1 attempting to leave their room, they would re-direct them. The Administrator indicated the facility did not have a [redacted] care or [redacted] unit. The Administrator revealed he expected the staff to follow the guidelines for [redacted] and make every effort to follow the isolation precautions when a resident had dementia and to document interventions attempted to protect all residents. New Jersey Administrative Code § 8:39-19.4(a)1-6	F 880		