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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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