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	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Arbor at Laurel Circle	100 Monroe Street Bridgewater, NJ 08807

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and review of pertinent documentation provided by the facility it was determined that the facility failed to implement the facility's abuse policy to ensure reference checks were completed for 18 of the 52 (Employee #1 through #18) newly hired employees reviewed since last survey of 9/13/2024. This deficient practice was evidenced by the following:1/13/2026, the surveyors reviewed the provided employee files which did not reveal reference checks for the following employees.Employee #1 with a date of hire (DOH) of 10/20/2025Employee #2 with a DOH of 9/2/025Employee #3 with a DOH of 10/21/2025Employee #4 with a DOH of 10/20/2025Employee #5 with a DOH of 1/29/2025Employee #6 with a DOH of 6/4/2025Employee #7 with a DOH of 3/27/2025Employee #8 with a DOH of 12/9/2024Employee #9 with a DOH of 7/28/2025Employee #10 with a DOH of 10/18/2024Employee #11 with a DOH of 10/22/2025Employee #12 with a DOH of 9/20/2025Employee #13 with a DOH of 10/29/2024Employee #14 with a DOH of 7/28/2025Employee #15 with a DOH of 10/1/2025Employee #16 with a DOH of 9/29/2025Employee #17 with a DOH of 9/2/2025Employee #18 with a DOH of DOH 4/9/2025 On 1/13/2026 at 11:37 AM, the surveyor interviewed the Human Resources Specialist (HRS), who stated reference checks were not done because from past experience people can lie. Background checks take care of that. He stated the facility does do employment verification. On 1/13/2026 at 12:32 PM, during a meeting with the survey team and the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) stated reference checks were absolutely done by the HRS. The surveyor asked how the facility would know if a potential new employee was a good performer, the DON stated, I believe the [name redacted-HRS] calls for a reference. The LNHA stated they (the facility) would follow up. The surveyor requested reference checks for the above mentioned 18 employees. On 1/14/2026 at 10:20 AM, during a meeting with the survey team, the DON, and the Assistant Living Manager, the LNHA stated the facility policy does not speak to reference checks. He provided the team with additional information which was a typed Hiring Process document. A review revealed We only do background checks. We do not do reference checks. In our experience reference checks only provide verification of employment. The surveyor presented the facility provided Abuse Prevention Policy. The LNHA reviewed the policy at that time and acknowledged the policy included reference checks. He then acknowledged the above requested reference checks were not available. A review of the facility's Abuse Prevention Policy revised 11/2017 revealed Pre-Employment Screening of Potential Employees.Prior to a new employee starting a work schedule, this community will: Initiate a reference check from previous employer (s), in accordance with community policy. NJAC 8:39-9.3(b)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315445	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Arbor at Laurel Circle	100 Monroe Street Bridgewater, NJ 08807

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to change respiratory equipment in a manner to prevent contamination for infection control. This deficient practice was identified for 1 of 3 residents reviewed for respiratory care (Resident #23), and was evidenced by the following:On 1/9/26 at 11:13 AM, during the initial tour of the facility, the surveyor observed Resident #23 in their bedroom seated in their wheelchair. The surveyor observed an oxygen concentrator (device that delivers oxygen) with nasal cannula (device that delivers additional oxygen through the nose) tubing placed on the oxygen concentrator with a piece of clear tape with the date 12/5. The resident stated that they used oxygen at all times. The surveyor also observed a nebulizer machine located on the bedside table with tubing attached. The nebulizer mask tubing had a clear piece of tape with the date 12/5. A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; chronic diastolic congestive heart failure (diastolic heart failure, your heart's left ventricle becomes thick and stiff), hypoxemia (abnormally low oxygen levels in the blood), and hypertension (high blood pressure). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 11/11/26, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating a moderately impaired cognition. Further review of Section O, Resident #23 received oxygen therapy while residing at the facility. A review of the Order Summary Report included a physician's order (PO) dated 10/15/24, for continuous oxygen at 3 liters per minute (lpm) via nasal cannula. If oxygen saturation (percent of oxygen in a person's blood) is below 90% every shift related to hypoxemia. Further reviewed revealed a physician's order to change oxygen tubing weekly every night shift every Wednesday. A review of the individual comprehensive care plan (ICCP) included a focus area dated 2/10/24, that the resident needed oxygen therapy related to congestive heart failure. Interventions included but were not limited to; oxygen via nasal cannula at 3 lpm continuously. On 1/13/26 at 10:19 AM, the surveyor interviewed the Registered Nurse (RN), who stated that oxygen tubing and nebulizer tubing should be changed weekly every Wednesday by the nurse. She further stated that the oxygen and nebulizer tubing should be dated when it was changed. The RN also stated that the tubing should not remain on the oxygen concentrator past 7 days. The RN further stated that the tubing should be changed weekly for infection control purposes. The RN acknowledged that the oxygen tubing and nebulizer tubing pictures taken on the initial tour were dated 12/5 and stated that they should have been changed weekly. On 1/13/26 at 10:26 AM, the surveyor interviewed the Director of Nursing (DON), who stated their expectations for their nursing staff was to check the oxygen and nebulizer tubing daily, make sure the devices were functioning properly, and to ensure the tubing was changed weekly. She stated that the tubing should be change weekly and as needed. The DON further stated that the tubing should not remain on the oxygen concentrator past 7 days. The DON further stated that the tubing should be changed weekly for cleanliness and sanitation purpose. When the surveyor presented the oxygen and nebulizer tubing pictures that were taken on the initial tour, she verified and acknowledged that the oxygen tubing and nebulizer tubing were dated 12/5. She further stated that the nurse should have changed them weekly. On 1/14/26 at 10:20 AM, the DON, in the presence of the Licensed Nursing Home Administrator (LNHA), Assistant Living Manager and the survey team, confirmed that oxygen and nebulizer tubing should be changed weekly. The DON stated that it was something that was just missed and acknowledged that the tubing was dated 12/5. A review of the facility's Humidifier and Oxygen Tubing Changes policy undated, included.this policy is to ensure the correct and safe changing of humidifier bottles on a routine basis to reduce the risk of nosocomial infections.change humidifier bottles and oxygen tubing weekly. NJAC 8:39-27.1 (a)