New Jersey Department of Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
		03015	B. WING		C 09/30/2021			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	ATE, ZIP CODE				
LAUREL BROOK REHABILITATION AND HEALTHCAR 3718 CHURCH ROAD								
LAUREL	SKOOK KEHABIEHAHO	MOUNT LA	AUREL, NJ 08	054				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE			
S 000	Initial Comments		S 000					
	THE FACILITY WAS 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 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.		S 560		10/22/21			
	by: Based on interview a documentation, it wa failed to maintain the care staff-to-resident state of New Jersey This deficient practic all residents. Findings include: Reference: NJ State 112. An Act concerni nursing homes and s Revised Statutes. Be It Enacted by	In is not met as evidenced and review of pertinent facility is determined that the facility required minimum direct ratios as mandated by the for 21 of 21 shifts reviewed. The had the potential to affect requirement, CHAPTER and staffing requirements for supplementing Title 30 of the the Senate and General to of New Jersey: C.30:13-18		1.No residents were identified. 2.All residents have the potential to be affected. 3. Administrator, Director of Nursing, Human Resources Director, and Staff Coordinator were re-educated on the minimum staffing requirements on 10/14/21. Administrator, Director of Nursing, Human Resources Director, Staffing Coordinator will meet three tirper week to review recruitment efforts staffing patterns for the current week at the upcoming week. Trends identified	ing and mes and and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed

10/19/21

New Jersey Department of Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION							
						С	
		03015		B. WING		09/30/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STE	REET ADDR	RESS, CITY, STA	TE, ZIP CODE		
I ALIREL E	RROOK REHARII ITATIOI	N AND HEALTHCAR	18 CHUR	CH ROAD			
LAUNCE	SKOOK KENABIENANOI	MC	OUNT LAU	JREL, NJ 080	054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	E
S 560	Continued From page 1			S 560			
S 560	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		S 560	the meetings will be presented during monthly QAPI meeting. Facility will continue to conduct weekly orientation onboarding to enroll new staff membe Also, facility has contracted with multipagencies to supplement filling open should be added to supplement filling open should be accorded to supple	a and rs. ple ifts. s, II ew fied will prts ng e or g y vill		
	day shift.	NAs for 188 residents on th					

New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _				
				D WING		C	
		03015		B. WING		09/30	0/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
3718 CHURCH							
LAUREL	BROOK REHABILITATION	N AND HEALTHCAR	MOUNT LA	UREL, NJ 080	054		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATIO		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETE DATE
S 560	Continued From page	2		S 560			
	day shift.						
	- 9/3/21 had 17 CN	NAs for 188 residents or	n the				
	day shift.						
		NAs for 188 residents or	n the				
	day shift.						
		NAs for 190 residents or	n the				
	day shift.		- 46				
	 9/6/21 had 16 CN day shift. 	NAs for 190 residents or	n ine				
		NAs for 184 residents or	n the				
	day shift.	The for for redigente of					
	•	NAs for 184 residents or	n the				
	day shift.						
		NAs for 174 residents or	n the				
	day shift.						
		CNAs for 184 residents	on				
	the day shift 9/11/21 had 19 CNAs for 190 residents on the		an tha				
	day shift.	NAS IOI 190 TESIDENIS (on the				
	-	NAs for 190 residents	on				
	the day shift.						
	- 9/13/21 had 18 C	NAs for 188 residents	on				
	the day shift.						
		CNAs for 188 residents of	on				
	the day shift.						
		CNAs for 185 residents	on				
	the day shift.	NAs for 185 residents	on				
	the day shift.	MAS IOI TOO TESIGETIIS (JII				
	,	NAs for 185 residents	on				
	the day shift.						
		NAs for 185 residents	on				
	the day shift.						
	On 10/06/2021 at 4:1	0 PM, the surveyor					
		e interview with the Dire					
		o stated that she was a	ware				
		ng requirements. DON					
		was actively trying to re					
	staff by offering bonus	ses to the staff. The fac	cility				

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		IDENTIFICATION NUMBER:							
						:			
03015		B. WING		09/30/2021					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
3718 CHURCH ROAD LAUREL BROOK REHABILITATION AND HEALTHCAR									
		MOUNT LA	UREL, NJ 08	054		Т			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
S 560	Continued From page	e 3	S 560						
S 560	an on-call program w The facility was holdi schools and colleges were offering tuition in Certified Nurse Aide also stated that the fa		S 560						