STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

(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 #: NJ 126470, NJ 127123 Census: 182 Sample Size: 4	F 000		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §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, This REQUIREMENT is not met as evidenced by: Complaint # NJ 126470 Based on interviews and review of the medical record (MR) and other facility documentation it was determined that facility staff failed to report and investigate injuries of unknown origin according to facility policy for 1 of 3 sampled residents reviewed for abuse protocol (Resident #2). This deficient practice is evidenced by the following; 1. According to the facility "Admission Record" Resident # 2 was admitted on [redacted] with diagnoses which included but were not limited to; [redacted],	F 607	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by Provider of the truth or the facts alleged, or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State laws that require it. 1. Resident # 2 was transferred to an acute care hospital on [redacted] 2. All residents have potential to be affected by the practice identified in the statement of Deficiencies. Nursing administration has completed an audit of	9/27/19

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

Electronically Signed | 09/26/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

(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 607	Continued From page 1 [redacted]. A Minimum Data Set (MDS), an assessment tool, dated [redacted] revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated [redacted] cognitive impairment. The MDS indicated the resident needed assistance with all activities of daily living (ADLs) and was at risk for [redacted]. A facility care plan (CP), initiated on [redacted] included that the resident was at risk for [redacted] related to (r/t) [redacted] problems, impaired safety awareness, history of [redacted] and use of [redacted] medications, and was incontinent. Interventions included but were not limited to; anticipate and meet needs and use of a wheelchair (w/c) when ambulating, weekly skin checks and observe skin during daily care. Review of an "Admission Nursing Evaluation" completed by 3-11 shift Registered Nurse (RN) Supervisor #1 and dated [redacted] had instructions to "conduct head to toe skin assessment and document all identified areas." RN #1 documented; "No skin issues identified." Additionally, review of weekly "Skin Observation Tool" sheets (skin assessments/SA) completed on [redacted] indicated "skin intact without discoloration and on 7[redacted] revealed; "skin intact." During an interview with the surveyor on 8/15/2019 at 10:00 am, the Registered Nurse (RN) Unit Manager (UM) for Resident #2's unit stated that at some point during the resident's stay at the facility a [redacted] came to her and showed her a [redacted] on the residents	F 607	current residents to ensure skin observation tool was completed to accurately reflect resident skin condition 3. All licensed nurses will be provided education regarding completing facility Admissions Nursing Evaluation and weekly skin observation tool. In addition, all licensed nurses will receive mandatory in-servicing on identifying, reporting, and investigating [redacted] or injuries of unknown origin. 4. For the next 3 months the Administrator, Director of Nursing, and/or her designee will audit all admissions/readmissions completed Admission Nursing Evaluation to ensure accurateness. In addition, DON and/or her designee will audit 25% of long-term care residents weekly skin checks to ensure any potential [redacted] of unknown origin was reported and investigated. The Administrator and/or her designee will report all findings to the QAPI committee on a monthly basis. Audits will remain in place for 3 months, and until the committee has identified substantial compliance. Completion Date: September 27 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

(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 607	Continued From page 2	F 607		

right (R) forearm and asked her what it was from. The RN UM stated it was approximately [redacted] color. The RN UM stated it did not look like a [redacted] and it looked like the resident may have "hit" something. The RN UM stated she told the[redacted] that it may have been that the resident bumped it and that "older people are sensitive."

The surveyor asked the RN UM if she initiated an investigation to determine how the resident obtained the[redacted] and the RN UM stated she did not know how the resident got the [redacted] and she did not check to see if a prior incident report (IR) had been completed.

The RN UM confirmed that she did not report the [redacted] to anyone, she did not document it in the progress notes (PNs) or complete a facility Risk Assessment Form/IR. The RN UM stated she began working at the facility in [redacted] and now would document a[redacted] of unknown origin on a Risk Assessment Form.

Review of a facility "Fall Details Report" (Incident Report for a fall/IR) completed by RN #1 and dated [redacted] at 5:00 pm revealed Resident #2 was sitting in a chair near the nursing station, got up, lost her balance and landed on the floor on her[redacted] RN #1 documented that she attempted to prevent [redacted] from hitting [redacted] on the floor. The resident denied[redacted] there were no injuries.

A SA completed by RN #1 after the fall, dated [redacted] at 11:11 pm revealed '[redacted] already existed prior to fall."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

(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 607	Continued From page 3	F 607		

A Nurse Practitioner (NP) Note, dated [redacted] at 1:44 pm indicated the resident was seen for a complaint of [redacted]. The NP documented that the resident was noted with "[redacted] of the skin resulting from [redacted] healing [redacted]."

Review of progress notes (PN) from admission through [redacted] did not reveal any documentation r/t [redacted].

The surveyor requested any investigations/IRs r/t the aforementioned skin observations, however, the Director of Nursing (DON) confirmed there were no IRs for any skin issues r/t Resident #2.

During a telephone interview with the surveyor on 8/14/2019 at 3:50 pm, RN #1 stated she did not investigate the discolorations to the [redacted] and [redacted] because they were already there prior to the fall. She confirmed that any injury of unknown origin such as discoloration, bruise, scratch or abrasion to a resident's skin was to be reported right away. She stated an IR is completed and an investigation is started to determine the cause.

During an interview with the surveyor on 8/15/2019 at approximately 11:30 am, the DON confirmed that IRs and investigations are initiated for injuries of unknown origin.

Resident #2 was discharged from the facility prior to the survey.

Review of a facility policy titled "Abuse Investigation and Reporting," dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

(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 607	Continued From page 4 "Revised...April 2018" included but was not limited to; All reports of resident abuse, neglect...mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies...and thoroughly investigated by facility management. findings of abuse investigations will also be reported. Role of the Administrator: If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual..." NJAC 8:39-27.1 (a)	F 607		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 127123 Based on interviews and review of the medical record (MR) and other facility documentation, it was determined that the facility failed to consistently document and/or administer a treatment according to physician orders (POs) and nursing standards of practice for 1 of 4 sampled residents (Resident #3). This deficient practice is evidenced by the following; 1. According to the facility "Admission Record," Resident #3 was admitted in [redacted] Diagnoses included but were not limited to; [redacted]	F 658	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by Provider of the truth or the facts alleged, or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State laws that require it. 1. Director of Nursing reviewed physician orders for Resident # 3 on [redacted], eTARS and [redacted] treatments to ensure treatment was rendered by licensed nursing staff according to	9/27/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

(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 658	Continued From page 5 [redacted] A Minimum Data Set (MDS), an assessment tool, dated [redacted] revealed a Brief Interview of Mental Status (BIMS) score of [redacted] which indicated [redacted] cognition and the resident needed assistance with activities of daily living (ADLs) including bathing. A care plan (CP), revised [redacted], included that the resident had the potential/actual [redacted] development related to (r/t) impaired mobility. Interventions included but were not limited to; [redacted] consult and treat as ordered. A Physician "Order Summary Report" (POS) revealed a physician order (PO) initiated [redacted] to; cleanse [redacted], pat dry, apply [redacted]) and cover with border gauze twice daily (BID) and evening shift for shearing to the [redacted] and discontinue (d/c) when healed. Review of the 7/2019 and 8/2019 electronic Treatment Administration Record (e-TAR) confirmed the aforementioned PO. For 5 of 22 opportunities from 7/23 through 8/2/2019 the e-TAR was not initialed/signed by a nurse to indicate if the treatment was done on the following dates and shift; [redacted] (all on the 3-11 shift), [redacted] (7-3 shift). There was no indication in the progress notes (PNs) on the aforementioned dates that the treatments were/were not administered. Additionally, a PO, initiated [redacted], revealed to; cleanse [redacted] pat dry, apply	F 658	physician orders. DON audited eTARS on 08/16/ 19 to ensure no further omissions, Resident # 3 discharged to home on [redacted]. 2. All residents with the potential/actual pressure ulcer development have the potential to be affected by the practice identified in the Statement of Deficiencies. On 08/16/19 DON and the Unit Managers audited eTARS of current residents to ensure all eTARS were initiated/signed by the nurse to indicate treatment was rendered per physician□s order. 3. All licensed nurses will be in-serviced by the facility educator and/or designee to ensure resident eTARS are initialed/signed by the nurse per physician□s order. Education will include review of the facility policies: Charts and Documentation and [redacted] Care policy. 4. For the next 3 months DON and/or her designee will audit 25% of all residents eTARS to ensure eTARS are initialed/signed by the nurse according to physician□s orders. The Administrator and/or designee will review the results of these audits, including any action taken for corrections. Results will be reviewed by the monthly QAPI committee. Completion Date: September 27 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

(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 658	Continued From page 6	F 658		

[redacted] and cover with border gauze daily and as needed (prn).

Review of the 8/2019 e-TAR confirmed the PO and for 1 of 5 opportunities from 8/3 through 8/7/2019 the e-TAR was not initialed/signed on [redacted] by a nurse to indicate if the treatment was done. There was no indication in the progress notes (PNs) on the aforementioned date that the treatment was/was not administered.

Review of weekly wound skin assessments from 7/24 through 8/14/2019 revealed the stage 2 [redacted] injury, present on admission had decreased in size.

During an interview with the surveyor on 8/15/2019 at approximately 2:00 pm, the Director of Nursing (DON) confirmed that all treatments were to be documented on the TAR by the nurse to indicate the treatment was/was not administered.

Review of a facility polity, revised 9/2018 and titled "Charting and Documentation" included but was not limited to; "All services provided to the resident...shall be documented in the resident's medical record...Documentation in the medical record may be electronic, manual or a combination. The following information is to be documented in the resident medical record:...Treatments or services performed...documentation in the medical record will be objective, complete, and accurate..."

Review of a facility policy dated 4/2016 and titled; [redacted] Care" included but was not limited to; "The purpose of this procedure is to provide guidelines for the care of [redacted] to promote

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

(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 658	Continued From page 7 healing;...Documentation The following information should be recorded in the resident's medical record: 1. the type of [redacted] care given. 2. The date and time the [redacted] care was given...4. the name and title of the individual performing the [redacted] care...10. the signature and title of the person recording the data..." NJAC: 8:39-27.1 (a)	F 658		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		9/27/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

(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 842	Continued From page 8 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

(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 842	Continued From page 9 Complaint #: NJ 127123 Based on observations, interviews and review of the medical record (MR) and other facility documentation, it was determined that the facility failed to maintain complete and accurate MRs for documentation of resident showers according to facility policy and protocol for 2 of 4 sampled residents. This deficient practice is evidenced by the following; 1. According to the facility "Admission Record," Resident #3 was admitted in [redacted]. Diagnoses included but were not limited to; [redacted] Brain, Seizures and Anxiety Disorder. A Minimum Data Set (MDS), an assessment tool, dated [redacted] revealed a Brief Interview of Mental Status (BIMS) score of [redacted] which indicated [redacted] cognition and the resident needed assistance with activities of daily living (ADLs) including bathing. A care plan (CP), initiated [redacted] included that the resident had an ADL self-care performance deficit related to (r/t) limited mobility, [redacted] Interventions included but were not limited to the use of one person assist for bed mobility, dressing and transfers. Review of a unit shower schedule indicated Resident #3 was to receive a shower two times weekly; on the 7-3 shift on Thursdays (TH) and the 3-11 shift on Mondays (M). Review of the Physician "Order Summary Report" (POS) for [redacted] through [redacted] revealed a physician order (PO), initiated [redacted] for	F 842	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by Provider of the truth or the facts alleged, or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State laws that require it. 1. Resident # 1 and Resident # 4 were offered showers on 08/15/19. Resident # 2 was transferred to an acute care hospital on [redacted]. 2. All residents requiring a shower per physician order have the potential to be affected by the practice identified by the Statement of Deficiencies. All residents requesting/requiring a shower were offered showers on 08/15/19 and 08/16/19. 3. All licensed nurses and certified nurses assistants will be in-serviced by the facility educator and/or designee regarding the proper documentation for resident showers. Education will include documenting in the POC all showers given as well as any refusals. In addition, licensed nurses and certified nurses assistants will be in-serviced on Facility policy: Shower/Tub bath. 4. For the next 3 months the DON and/or her designee will audit 25% of the Task report/POC to ensure showers are given/offered according to physician order. The Administrator and/or her designee will review findings and report to the monthly QAPI committee. Completion Date: September 27 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

(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 842	Continued From page 10	F 842		

showers every TH on the 7-3 shift and M on the 3-11 shift.

Review of Sampled Residents #1, #2 and #4 and Unsampled Resident #1's Certified Nurse's Aide (CNA) "Task" Documentation Survey Report (ADL Record) included an area to document "Bathing" every shift. In addition, for each of the aforementioned residents there was another area to document "Shower/Bath" and it indicated that the showers were to be administered twice weekly with instructions to document a "Yes" or "No" to indicate if the resident received a shower.

Review of Resident #3's 7/2019 and 8/2019 Certified Nurse's Aide (CNA) "Task" Documentation Survey Report had an area to document "Bathing" every shift and for 22 of 23 days in [redacted], daily bathing was documented as given. On [redacted] there was no documentation that the resident was bathed. There was no area on Resident # 3's CNA "Task" sheet for a CNA to initial/sign off, that the resident received a shower from [redacted] through [redacted] for a total of 10 of 10 opportunities.

Review of the 7/2019 and 8/2019 Medication Administration Record (MAR) confirmed the PO for showers twice weekly. From [redacted] through [redacted] for a total of 2 of 8 opportunities, there was no documentation that the resident received and/or refused a shower; on TH, [redacted] and M, [redacted] There was no indication in the progress notes (PNs) that the resident received a shower on those dates.

During an interview and observation by the surveyor on 8/14/2019 at approximately 11:00 am in the presence of a [redacted], Resident #3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

(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 842	Continued From page 11	F 842		

was well groomed and confirmed he was bathed daily by staff. Resident #3 stated he did not remember receiving a shower in the facility.

Review of a statement emailed to the surveyor on 8/19/2019 from the facility Director of Nursing (DON) indicated the resident preferred bed baths to showers.

2. According to the "Admission Record," Resident #4 was admitted in [redacted] with diagnoses which included but were not limited to; [redacted]

An MDS, dated [redacted], revealed the resident had a "BIMS" score of [redacted] which indicated moderate cognitive impairment and the resident needed assistance with ADLs.

A CP, initiated [redacted] revealed the resident had an ADL Self Care Performance deficit r/t [redacted]. Interventions included but were not limited to one person assist for ADLs and mobility.

Review of Resident # 4's 7/2019 CNA "Task" Documentation Survey Report revealed the resident was to receive showers two times weekly on the 3-11 shift on Fridays (F) and M. The "Task" report included an area for the CNA to initial/sign off that the resident received a shower. For 5 of 9 opportunities there was no documentation that the resident received a shower on the following dates; [redacted] and [redacted]. Additionally, there was no documentation on the MAR or in the PNs to indicate the resident received showers on those days. The "Task" Report had documentation that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING _____ B. WING _____	C 08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

(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 842	Continued From page 12 the resident was bathed daily. During a post survey telephone interview with the surveyor on 9/5/2019 at 4:06 pm, there DON confirmed that residents were to receive showers twice weekly and staff should document in the MR when a resident did/did not receive a shower. Review of a facility policy dated 4/2016, titled; "Shower/Tub Bath" included but was not limited to; "...The following information should be recorded on the resident's ADL record and/or the resident's medical record: 1. The date and time the shower...was performed. 2. The name and title of the individual(s) who assisted the resident with the shower... 5. If the resident refused the shower..., the reason(s) why and intervention taken. 6. The signature and title of the person recording the data..." NJAC: 35.2(d) 9	F 842		