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 _____	04/28/2021

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 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. Survey Date : 04/28/2021 Census : 161 Sample Size : 32+23= 55	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		5/13/21

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

Electronically Signed | 05/06/2021

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 _____	04/28/2021

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 690	Continued From page 1 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent documents, it was determined that the facility failed to follow appropriate infection control practices during Executive Order 26, 4.b. care. This deficient practice was identified for 1 of 2 residents reviewed, (Resident #103) for Executive Order 26, 4.b. and was evidenced by the following: On 04/21/21 at 10:34 AM, the surveyor observed Resident #103 lying in bed. A Executive Order 26, 4.b. was in place and Executive Order 26, 4.b. into an indwelling Executive Order 26, 4.b. that was at the of the resident's On 04/26/21 at 10:58 AM, the surveyor observed the Licensed Practical Nurse (LPN) perform Executive Order 26, 4.b. to Resident #103. The surveyor observed the LPN use her bare hands to turn the water faucet on. The LPN then obtained supplies which included liquid soap, gloves, and a basin. The surveyor further observed the LPN fill the basin with warm water and then place a washcloth into the basin of water. On 04/26/21 at 11:01 AM, the surveyor observed	F 690	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the 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 #103 identified in the Statement of Deficiencies (SOD) was Executive Order 26, 4.b. post incident with no signs or symptoms of infection or discomfort. There were no negative outcomes noted. MD was notified on Executive Order 26, 4.b. and no change in plan of care was needed. On Executive Order 26, 4.b., in-service education on proper catheter care practices including hand hygiene and infection control protocols were provided to the Licensed Practical Nurse (LPN) identified in the SOD. 2. All residents with catheters have the potential to be affected. An audit of all residents with catheters was completed on 4/26/2021 and no concerns were noted. 3. The Infection Preventionist and/or	

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 _____	04/28/2021

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 690	Continued From page 2 the LPN exit Resident #103's room and obtained a Executive Order 26, 4.b. from the treatment cart located outside of the room. The LPN reentered Resident #103's room, closed the door, and used her bare hands on the bed control to raise the bed to a working height. On 04/26/21 at 11:03 AM, the LPN donned (put on) gloves, Executive Order 26, 4.b. the Executive Order 26, 4.b. Executive Order 26, 4.b. Resident #103's Executive O and moved the trash can closer to the resident's bed. The surveyor observed that the LPN had not performed hand hygiene after entering the room and closing the door, then after handling supplies, before or after using the bed control, or prior to donning gloves. On 04/26/21 at 11:05 AM, the LPN Executive Order 26 Resident#103's Executive Order 26, 4.b. The surveyor observed that the LPN wearing the same gloves, pick up the liquid soap and apply the liquid soap to the wet washcloth. The LPN, still wearing wearing the same gloves, cleansed the resident's Executive Order 26, 4.b. located in the Executive Order 26, 4.b. and Executive Order 26, 4.b. Executive Order 2 On 04/26/21 at 11:09 AM, the LPN still wearing the same gloves, reached her right hand into her right scrub jacket pocket and pulled out a sharpie marker. The LPN applied a new clean dressing to the newly cleaned Executive Order 26, 4.b.. The surveyor observed that the LPN was wearing the same gloves while she performed this task. On 04/26/21 at 11:10 AM, the surveyor observed the LPN, while wearing the same gloves, open the Executive Order 26, 4.b. and Executive O the Executive Order 26 with the sharpie she had just removed from her	F 690	designee will re-educate all licensed nurses on proper catheter care procedures including infection control and hand hygiene protocols during catheter care. Education will be completed by 5/12/2021. 4. The Infection Preventionist and/or designee will complete three random catheter care audits weekly for four weeks. After that, three random catheter care audits will be completed monthly for three months. Results of the audits will be reported to the monthly Quality Assurance Performance Improvement committee for review. The Quality Assurance Performance Improvement committee will determine the need for further and continued action.	

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 _____	04/28/2021

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 690	Continued From page 3	F 690		

pocket. The LPN next removed the existing Executive Order 26, 4.b. and Executive Order 26, 4.b. the Executive Order 26, 4.b. to the Executive Order 26, 4.b.. The surveyor did not observe the LPN change gloves or perform hand hygiene while going from clean to dirty while performing the Executive Order 26, 4.b.

On 04/26/21 at 11:13 AM, the LPN wearing the same gloves, secured the Executive Order 26, 4.b. around the Executive Order 26, 4.b., readjusted the new clean Executive Order 26, 4 and Executive Order the resident's Executive Order 26, 4.b. The LPN did not change gloves or perform hand hygiene while handling both clean and dirty areas.

On 04/26/21 at 11:14 AM, the LPN wearing the same gloves, used her left gloved hand to pick up the bed control to lower the resident's bed and the right gloved hand to throw away the trash. The LPN next emptied the water basin and washcloth into the sink in the resident's room. The surveyor observed the LPN turn on the water to the sink, rinse the basin, and then dried the basin with clean paper towels. The LPN continued wearing the same gloves.

On 04/26/21 at 11:15 AM, the LPN removed her gloves, gathered the soap and other resident supplies and placed the basin and supplies back into the resident's drawer which was located next to the resident's bed. The LPN did not perform hand hygiene after removing her gloves.

On 04/26/21 at 11:15 AM, the surveyor observed the LPN turn on the faucet to the sink with her bare hands and wash her hands for 21 seconds. As the LPN was performing hand hygiene, the used washcloth remained in the sink.

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 _____	04/28/2021

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 690	Continued From page 4 On 04/26/21 at 11:17 AM, the LPN exited the resident's room and then returned with a plastic bag. The LPN then used her bare hands to put the used washcloth in the plastic bag. The surveyor interviewed the LPN on 04/26/21 at 11:20 AM. The LPN stated she should have changed gloves and washed her hands after she gathered the supplies, cleaned the [redacted] area, and after applying the dressing to the residents [redacted]. The LPN stated she should not have worn the same gloves when she reached into her scrub pocket to remove the sharpie. The LPN further stated she should have changed gloves and performed hand hygiene for infection control purposes. The LPN stated she should not have touched Resident #103's bed control while wearing dirty gloves because she could spread infection. During an interview on 04/26/21 at 11:39 AM, the Director of Nursing stated the LPN should have performed hand hygiene between several steps such as after set up, after obtaining the basin water, after touching the trash can and going from dirty to clean areas in order to prevent cross contamination. During an interview on 04/28/21 at 9:21 AM, the Registered Nurse Infection Preventionist stated the LPN should have appropriately performed hand hygiene prior to donning gloves while providing [redacted] to prevent the spread of infection. The surveyor reviewed the medical record for Resident #103.	F 690		

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 _____	04/28/2021

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 690	Continued From page 5 Review of the Admission Record revealed Resident #103 had been Executive Order 26, 4.b. in [redacted] and had diagnoses which included but were not Executive Order 26, 4.b. [redacted] Review of the resident's most recent quarterly Minimum Data Set, MDS (an assessment tool used to facilitate the management of care) dated [redacted] reflected that the resident had a [redacted] Interview of Executive Order 26, 4.b. [redacted] which indicated the resident [redacted] Executive Order 26, 4.b. [redacted] Executive Order 26, 4.b. A further review of [redacted] Executive Order 26, 4.b. [redacted] MDS reflected that the resident [redacted] Executive Order 26, 4.b. Review of the April 2021 Order Summary Report (OSR) reflected a Physician's Order (PO) dated [redacted] for Executive Order 26, 4.b. [redacted] care every day shift A further review of the resident's [redacted] OSR reflected a PO dated [redacted] for [redacted] Executive Order 26, 4.b. [redacted] Executive Order 26, 4.b. [redacted] Executive Order 26, 4.b. [redacted] in the afternoon for a [redacted] [redacted] (CP) revised on 01/14/20 revealed that Resident #103 had a Executive Order 26, 4.b. [redacted]. A further review of the resident's CP revealed a focus area that the resident had an indwelling [redacted] Executive Order 26, 4.b. [redacted] The goal of the CP revealed that the resident would not show signs and symptoms of a [redacted] Executive Order 26, 4.b. [redacted] through the next review date. Interventions for the resident's CP reflected to provide [redacted] Executive Order 26, 4.b. as needed and the resident	F 690		

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 _____	04/28/2021

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 690	Continued From page 6 preferred to use a [redacted] at all times and to please change it every day. Review of the, "Urinary Leg Drainage Bags Competency", revealed the procedure which included but was not limited to wash and dry hands thoroughly after placing clean equipment on bedside stand and to remove gloves after; wash and dry hands thoroughly after applying the new leg bag and discarding disposable items; wash and dry your hands thoroughly, apply gloves, and wipe the Foley catheter before disconnecting; connect the Foley catheter with the urinary leg drainage bag, anchor as directed and to remove gloves and wash and dry your hands thoroughly. Review of the facility, "Hand Hygiene Competency", dated 12/2020, revealed the LPN had been deemed competent in hand washing and the use of the alcohol-based hand rub. Review of the facility, "Urinary Leg Drainage Bags", policy and procedure undated, included but was not limited to the purpose of the procedure was to provide guidelines to decrease the likelihood of nosocomial (originating in the facility) urinary tract infections associated with the intermittent use of leg drainage bags with catheters; aseptic technique must be used when handling urinary drainage systems; place clean supplies on bedside stand and wash and dry hands thoroughly; after completion of procedure discard disposable items, remove gloves and wash and dry your hands thoroughly. Review of the facility, "Handwashing/Hand Hygiene", policy and procedure undated, included but was not limited to the purpose primary means	F 690		

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 _____	04/28/2021

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 690	Continued From page 7 to prevent the spread of infections; use alcohol-based hand rub or soap and water before and after direct contact with residents, before performing any non-surgical invasive procedure, before and after handling an invasive device, before handling clean or soiled dressings, after handling contaminated equipment, after contact with objects in the immediate vicinity of the resident and after removing gloves. NJAC 8:39-27.1(a)	F 690		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other pertinent documentation, it was determined that the facility failed to maintain a medication error rate below 5%. On 04/26/21, the surveyors observed 3 nurses administer 30 medications to 7 residents. There were 2 errors which resulted in an error rate of 6.67%. This deficient practice was identified for 2 of 7 residents (Resident #4 and #11) who were observed for medication administration. The deficient practice was evidenced by the following. On 04/26/21 at 07:41 AM, the surveyor observed a Licensed Practical Nurse (LPN) prepare and administer the medication Executive Order 26, 4.b.	F 759	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the 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. Residents #11 and #4 identified in the Executive Order 26, 4.b. were Executive Order 26, 4.b. and did not have any signs or symptoms of Executive Order 26, 4.b. . No negative outcomes noted. The MD was contacted and no change in plan of care	5/13/21

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 _____	04/28/2021

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 759	Continued From page 8 Executive Order 26, 4.b. to Resident #11. The LPN had not offered food to Resident #11. The surveyor observed Resident #11 in a Executive Order 26, 4.b. by their overbed table. There was no meal tray in the room and no food in the resident's environment. On 04/26/21 at 08:07 AM, the surveyor observed the LPN obtain a Executive Order 26, 4.b. for Resident #4. The results Executive Order 26, 4.b. The LPN informed Resident #4 that the Executive Order 26, 4.b. was for him/her and to "eat all your breakfast" when it arrives. The LPN administered the Executive Order 26, 4.b. to Resident #4. The LPN had not offered food to Resident #4. The surveyor observed Resident #4 in a Executive Order 26, 4.b. in their room. The surveyor observed that there was no meal tray in the room and there was no food in the resident's environment. On 04/26/21 at 08:20 AM, the surveyor observed the food cart arrive on the unit with the breakfast trays. The surveyor observed Resident #4's breakfast tray being delivered at 08:22 AM, 15 minutes after the resident swallowed the medication. At 8:27 AM, the surveyor observed Resident #11's breakfast tray being delivered. This was forty-six minutes after the resident swallowed the medication. During an interview on 04/26/21 at 8:18 AM, the LPN stated the purpose of administering the diabetic medications with meals was so the resident's blood sugar would not drop too low or	F 759	was needed. On 4/26/2021, the Licensed Practical Nurse (LPN) identified was re-educated on proper administration of the medications with meals as ordered, including following the prescriber's orders and the medication administration guidelines. 2. All residents that receive oral anti-diabetic medications have the potential to be affected. An audit of all residents who receive oral anti-diabetic medications was completed by 4/27/21 and no concerns were noted. 3. The Director of Nursing and/or designee will educate all licensed nurses on proper administration of oral anti-diabetic medications, including following the prescriber's orders and the medication administration guidelines on oral . Education will be completed by 5/12/2021. 4. The DON and/or designee will complete three audits of licensed nurses administering oral anti-diabetic medications to ensure that the medications are administered appropriately as ordered with meals. The three audits will be conducted weekly for four weeks, then monthly for three months. Results of the audits will be reported to the monthly Quality Assurance Performance Improvement committee for three months for review. The Quality Assurance Performance Improvement committee will determine the need for further and continued action.	

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 _____	04/28/2021

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 759	Continued From page 9	F 759		

irritate the resident's stomach. The LPN further stated she should have offered crackers to the residents because she was not aware of the time the breakfast trays were going to arrive on the unit, however, she thought they were going to arrive soon.

During an interview on 04/26/21 at 8:24 AM, the Director of Nursing stated if a medication was indicated to be given with a meal, it should be given when the meal tray was present because that was the physician's recommendation.

During an interview on 04/26/21 at 8:32 AM, the Certified Nursing Assistant on the unit stated the meal tray carts were not always on time and that she was never instructed to bring a tray to any specific resident first.

During an interview on 04/26/21 at 8:54 AM, Resident #11 stated her/his medication would be given first and the breakfast tray would come up later on.

During an interview on 04/26/21 10:00 AM, Resident #4 stated she/he takes the Executive Order 26 medication before the breakfast meal was delivered. Resident #4 stated it could be a while before breakfast came up but he/she was not sure exactly how long it would be before it arrived.

Review of the Admission Record revealed Resident #11 had been Executive Order 26, 4.b. which included but were Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b.).

Review of Resident #11's Executive Order 26, 4.b. Order

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 _____	04/28/2021

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 759	Continued From page 10 Summary Report (OSR) reflected a physician's order dated [redacted] for Executive Order 26, 4.b. [redacted] Review of the Admission Record revealed Resident #4 had been Executive Order 26, 4.b. [redacted] Review of Resident #4's [redacted] reflected a physician's order dated [redacted] for [redacted] A further review of the resident's [redacted] OSR reflected a physician's order dated [redacted] for Executive Order 26, 4.b. Executive Order 26, 4.b. medication with meals. Review of the facility, "Administering Medications Competency", dated 01/07/21, revealed the LPN deemed competent during medication administration. Tasks included but were not limited to verify there is a physician's medication order for this procedure and follow the medication administration guidelines. Review of the facility, "Administering Medications", policy and procedure revised 9/2020, revealed but was not limited to medications are administered in accordance with prescribers orders and medications are administered within one hour of their prescribed time, unless otherwise specified (for example meal orders). NJAC 8:39-29.2(d)	F 759		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		5/13/21

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 _____	04/28/2021

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 812	Continued From page 11 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review it was determined that the facility failed to ensure staff properly secured facial hair and maintain food storage or preparation items in a clean and sanitary manner to prevent cross-contamination and limit the potential for microbial growth. The deficient practice was evidenced by the following: On 04/26/21 during a tour of the kitchen from 12:21 PM through 12:40 PM in the presence of the dietary director (DD) the surveyor observed: 1. The lunch tray line preparation was in progress	F 812	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the 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. No residents were negatively affected. The plastic wrap identified in the Statement of Deficiencies (SOD) was discarded on 4/26/2021. On 4/26/2021, DW #1 identified in SOD put on a beard restraint and educated on using proper beard and hair restraint. The pans 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 _____	04/28/2021

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 812	Continued From page 12 and the surveyor observed a dietary staff member (DW #1) at the start of the tray line placing resident meal tickets on the meal trays. The DW #1 was wearing a surgical mask that covered his mouth area but his side facial hair extended out and was exposed. 2. Large shallow metal pans were stacked with the food contact surface area down and located on a rack. The DD stated the pans were clean. The DD removed the pans for the surveyor to visually inspect. The DD separated the stacked metal pans and six were observed as visibly wet inside of the pan. The DD removed the pans to be re-washed. 3. A container of bread crumbs and a container of instant mashed potatoes were located next to the tray line on a lower shelf of a stainless steel table. Both containers were soiled and had debris on the exterior of the containers. 4. An uncovered large plastic wrap container was located next to the tray line and on top of a stainless steel table. The container was visibly soiled with splatters on the exterior and inside of the container next to the plastic wrap. The surveyor interviewed the DD regarding the DW #1 exposed facial hair. The DD stated the facility had beard restraints available and DW #1 would have to wear two on his face. The DD did not explain why DW #1 did not have all of his facial hair covered or use a beard restraint. Review of an undated Sanitation policy revealed the food service are shall be maintained in a clean and sanitary manner. 10. Food preparation equipment and utensils that are manually washed	F 812	were not in circulation for use, noted as wet nested were removed from the rack and rewashed. The mashed potatoes and breadcrumbs noted by the surveyor as soiled were discarded. Also, on 4/26/2021, all dietary staff were provided with in-service education on maintaining food storage and preparation items in a clean and sanitary manner to prevent cross contamination and limit the potential for microbial growth. 2. All residents who consume food by mouth have the potential to be affected. No food borne illness were noted in the facility in the immediate 48 hours post incident. 3. The Food Service Director and/or designee will complete education to all dietary staff on preventing food borne illness as well as proper employee hygiene and sanitary practices. The education will include beard and hair guard in-services to all dietary staff. The Food Service Director and/or designee will complete education for maintaining food storage and preparation items in a clean and sanitary manner to prevent cross contamination and limit the potential for microbial growth. The education will include an in-service on the proper procedure to ensure that food preparation equipment and utensils that are manually washed will be allowed to air dry whenever practical and positioned in a manger that allows for air flow between items until dry. The food service Director and/or designee will complete education on ensuring that all containers including plastic wrap containers are clean and free	

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 _____	04/28/2021

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 812	Continued From page 13 will be allowed to air dry whenever practical and positioned in a manner that allows for air flow between items until dry. 11. Facility will designate an area for air drying. Periodically and prior to putting equipment or utensils back into normal storage/ usage areas, dietary staff will inspect to ensure that items are air drying properly. Any item not air drying properly will be removed from circulation if so indicated... Review of an undated Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices policy revealed the food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. 12. Hair nets or caps and/or beard restraints and/or articles that cover head or facial hair must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens. Review of the facility provided undated email from their local county health department revealed the local county health department was "unaware of a direct guideline that determines whether a beard restraint would need to be worn under or over a mask of an individual with facial hair that still protrudes from a mask." The email further revealed if a mask were to be used to act as a beard restraint also, it would need to effectively keep hair from contacting exposed food, clean equipment, utensils, linens and unwrapped single-service and single-use articles. On 04/28/21 at 10:47 AM, during an exit interview with the facility administration and survey team, the corporate operations director (COD) stated the metal pans were wet on a drying rack. The COD did not offer an explanation as to why the	F 812	of debris. All education will be completed by 5/12/2021. 4. The Food Service Director and/or designee will conduct three audits weekly for four weeks, then monthly for three months. The audits will ensure that all staff with facial hair is using beard guards appropriately. The Food Service Director and/or designee will conduct three audits weekly for four weeks, then monthly for three months to ensure that food preparation equipment and utensils that are washed will be allowed to air dry and positioned in a manner that allows for air flow between items until dry. The Food service Director and/or designee will conduct three audits weekly for four weeks, then monthly for three months to ensure that all containers including plastic wrap containers are clean and free of debris. Results of the audits will be reported to the monthly Quality Assurance Performance Improvement committee for three months for review. The Quality Assurance Performance Improvement committee will determine the need for further and continued action.	

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 _____	04/28/2021

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 812	Continued From page 14 pans were stacked wet. NJAC 8:39-17.3 (g)	F 812		
F 880 SS=D	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 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		5/18/21

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 _____	04/28/2021

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 880	Continued From page 15 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: Based on observation, interview and document review it was determined that the facility staff failed to a.) don (put on) appropriate personal protective equipment (PPE) upon entrance into residents' room who were on transmission-based precautions and resided on the persons under	F 880	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the Provider of the truth or the facts alleged, or conclusion set forth in the Statement of Deficiencies. This plan of correction is	

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 _____	04/28/2021

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 880	Continued From page 16 investigation unit (PUI) for COVID-19 and b.) perform hand-hygiene when indicated after removing PPE. This deficient practice was identified during a tour on 1 of 2 isolation units and for 2 out of 2 staff who were observed entering resident rooms (Resident # 262 and #263). The deficient practice was evidenced by the following: On 04/26/21 at 9:03 AM, while on the PUI unit, the surveyor observed a Certified Nurse Aide (CNA #1) exit the room of Resident #262 carrying a resident meal tray. CNA #1 was observed wearing an N-95 mask, goggles and gloves. CNA #1 proceeded to place the meal tray on a food cart and then removed her gloves. Without performing hand hygiene, CNA #1, then donned (put-on) a new pair of gloves and entered Resident #263's room without donning a PPE gown. Resident #263's room door was open and with a clear unobstructed view, the surveyor observed CNA #1 pick up the meal tray located on the resident's bedside table. CNA#1 was also observed coming in contact with the curtain that surrounded the Resident #263's bed. At 9:04 AM, the surveyor interviewed CNA #1 upon exiting Resident #263's room about the PPE that was to be worn when entering the PUI rooms of Resident #262 and Resident #263's. CNA #1 stated she was supposed to wear a PPE gown for protection since the residents were on isolation. The surveyor also inquired of CNA #1 what should be done when gloves are removed and new gloves are donned. CNA#1 stated she was supposed to perform hand hygiene and acknowledged she did not clean her hands after	F 880	prepared and/or executed because the provisions of Federal and State Laws that require it. 1. Residents #262 and #263 identified in the Executive Order 26, 4.b. SOD)were Executive Order 26, 4.b. did not have any negative effects because of the deficient practice. On 4/26/2021, CNA #1 and the social worker were re-educated on hand hygiene protocols and proper donning and doffing of personal protective equipment (PPE) when entering and exiting patient rooms on the PUI unit. 2. Residents residing on the PUI unit have the potential to be affected. Residents were monitored for signs and symptoms of infection with nothing remarkable noted. In accordance with Federal regulations at 42 CFR 488.424, a Directed Plan of Correction was imposed on the facility. As part of the Directed Plan of Correction a Root Cause Analysis (RCA) was completed. The SOD identified that CNA#1 and the SW failed to Don (put on) appropriate personal protective equipment (PPE) upon entrance into residents' room who were on transmission-based precautions and resided on the persons under investigation unit (PUI) for COVID-19 and; CNA #1 failed to perform hand-hygiene when indicated after removing PPE. The RCA identified that CNA #1 was	

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 _____	04/28/2021

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 880	Continued From page 17 removing gloves and prior to donning new gloves. At 9:10 AM, the surveyor interviewed another CNA (CNA #2) assigned to the PUI unit. The surveyor asked CNA #2 what was the PPE process to follow when entering a PUI resident's room. CNA #2 stated she knew she had to put a PPE gown on before she entered a room. At 9:27 AM, the surveyor observed an open door to Resident #262's room. A staff member was observed with his back to the inside of the door frame on the interior of the room. The staff member was standing within arms length of the resident and conversing with the resident who was in bed. The staff member was not wearing a PPE gown and had on an N-95 mask and goggles. A stop sign and an instructional sign on how to appropriately don and doff PPE were observed affixed to the resident's door. At 9:34 AM, the surveyor interviewed the staff member upon exiting Resident #262's room. The staff member identified himself as the facility social worker (SW). The surveyor inquired what type of precautions the resident was on and the SW stated the resident was on droplet precautions. The SW stated he should have worn a PPE gown. The SW stated the residents were on PUI because they may test positive for COVID-19. The SW further stated the resident was not wearing a mask while he conversed with him/her. The surveyor observed the red stop sign and another document affixed to Resident #262 and 263's room doors. The sign revealed "special droplet precautions, everyone must: including visitors, doctors and staff, clean hands when	F 880	experiencing PPE fatigue, forgot to Don a gown/perform hand hygiene because the CNA was rushing to collect the meal trays, stating that she was nervous that the state was in the building. The RCA identified that the SW was experiencing PPE fatigue and forgot to don a gown because he was only going to briefly talk to the resident, the SW stated that he always wears gowns into PUI rooms. He did report that he has been experiencing emotional struggles as the result of the death of his child and feels his mind may have been on other things that day. 3. Infection Preventionist and/or designee will provide in-service education to all facility staff on policy and procedure for hand hygiene, donning and doffing of PPE while working on the PUI or COVID positive unit. The education will be completed by 5/18/2021. As part of the Directed Plan of Correction the following additional education was provided: a. Nursing Home Infection Preventionist Training Course Module 1 - Infection Prevention & Control Program https://www.train.org/main/course/1081350/ Provide the training to: Topline staff and infection preventionist. b. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw Provide the training to: Frontline staff.	

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 _____	04/28/2021

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 880	Continued From page 18 entering and leaving the room, wear mask, wear eye protection and gown and glove at the door. The second document revealed under personal protective equipment to put on in this order: 1. wash or gel hands (even if gloves used), 2. gown 3. Mask and eye cover 4. gloves, and take off and dispose of in this order: 1. gloves 2. gown 3. wash or gel hands 4. mask and eye cover 5. wash or gel hands (even if gloves used). The surveyor observed bins of PPE and alcohol-based hand rub accessible to staff outside the PUI resident rooms. On 04/26/21 at 9:40 AM, the surveyor conducted an interview with the facility Infection Preventionist, Registered Nurse (IP/RN), in the presence of the Director of Nursing (DON), regarding what PPE must be worn to enter a PUI room. The IP/RN stated you must wear a PPE gown, N-95 mask and goggles. The IP/RN stated when the trays were removed from the PUI rooms the staff should be wearing gloves, a PPE gown, mask and when they remove their gloves, they should clean their hands. The IP/RN stated staff needed to wear the correct PPE when entering the PUI rooms and that the PPE gowns were to protected staff and kept their clothes clean. On 04/28/21 at 9:26 AM, the surveyor interviewed the IP/RN regarding the PUI unit. The IP/RN stated new and re-admissions were placed on the PUI unit because the facility did not know what they had been exposed to before admission. The residents on the PUI unit were there for 14 days on transmission-based precautions (TBP) to prevent the spread of the COVID virus. The PUI residents were on droplet precautions and the PPE required included the N-95 mask, goggles or	F 880	c. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for COVID-19 https://youtu.be/YYTATw9yav4 Provide the training to: Frontline staff. d. Nursing Home Infection Preventionist Training Course Module 7 - Hand Hygiene https://www.train.org/main/course/1081806/ Provide the training to: All staff including topline staff and infection preventionist. As noted in the RCA the following additional education was completed: a. Education on the necessity of appropriate hand hygiene and appropriate use of PPE. b. Education to staff on strategies to combat PPE fatigue. 4. Infection Preventionist and/or designee will complete three audits weekly for four weeks then monthly for three months. The audits will be in the form of observations of staff members performing hand hygiene when indicated and donning and doffing of PPE while providing care and/or entering/exiting patient rooms on the PUI and COVID positive unit. Results of the observations will be reported to the monthly Quality Assurance Performance Improvement committee for three months for review. The Quality Assurance Performance Improvement committee will determine the need for further and continued action. As part to the RCA the Infection Preventionist and/or designee will collect	

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 _____	04/28/2021

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 880	Continued From page 19 a face shield, gloves, and the gown. The IP/RN stated that PPE needed to be donned no matter what and prior to crossing the threshold of the PUI resident's room. A review of the Executive Order 26, 4.b. list, provided by the IP/RN and DON, dated Executive Order 26, 4 revealed Resident #262 and #263 were on the PUI unit. The undated Isolation- Initiating Transmission Based Precautions Policy revealed Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Transmission based precautions may include Contact Precautions, Droplet Precautions or Airborne Precautions. When Transmission- Based Precautions are implemented, the Infection Preventionist (or designee): Clearly identifies the type of precautions, the anticipated duration, and the PPE that must be used, Determines the appropriate notification on the room entrance door and on the front of the resident's chart so that personnel and visitors are aware of the need for and type of precautions, the signage informs the staff of the type of CDC precautions (s), instructions for use of PPE, and/or instructions to see a nurse before entering the room... Review of the Standard Precautions policy revised December 2007 revealed under hand hygiene is performed with alcohol-based hand rub or soap and water after removing PPE. According to the U.S. Centers for Disease Control	F 880	data by conducting observations on two staff members daily, alternating shifts for five days to ensure proper hand washing, then two staff members, alternating shifts three times a week for one week, then two staff members weekly for two weeks. Results of the observations will be reported to the monthly Quality Assurance Performance Improvement committee for three months for review. The Quality Assurance Performance Improvement committee will determine the need for further and continued action.	

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 _____	04/28/2021

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 880	Continued From page 20 and Prevention (CDC) guidelines, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated Feb. 23, 2021" HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection" NJAC 8:39-19.4(a)(b)	F 880		

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
315524 Y1	A. Building B. Wing Y2	6/16/2021 Y3

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

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 F0690	Correction	ID Prefix F0759	Correction	ID Prefix F0812	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.45(f)(1)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	05/13/2021	LSC	05/13/2021	LSC	05/13/2021
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/18/2021	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
4/28/2021	☐ YES ☐ NO