STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING **01** 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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS LIFE SAFETY CODE 101:2012 THIS FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED UNDER CMS-2786R. Laurel Brook Rehab and Healthcare is a two-story building that was built in 1980's. It is composed of Type V (111) construction and is fully sprinklered. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms, There are two generators 1. North 1 Emergency Generator and Back Boiler room Generator. both natural gas units. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair,	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/11/2021

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K 000	Continued From page 1 alterations or additions. The survey process was modified during this COVID-19 PHE as allowed by QSO Memo 20-31-All. The process revisions excluded approximately 50% of the rooms and portions of the barriers. The facility has 220 certified beds. At the time of the survey the census was 161. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation on 04/28/21 in the presence of facility Maintenance Director, it was determined that the facility failed to provide 2 sources of illumination at exit discharges to the common way for evacuation. This deficient practice was evidenced by the following: 1. At 11:00 A.M., the surveyor observed at the egress door identified as #[redacted] by resident room [redacted] that the fixture contained one-bulb and the	K 281	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.Maintenance Director/ designee replaced the one-bulb fixtures identified in	5/14/21

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K 281	Continued From page 2 surrounding area was not provided with enough overlapping light pattern from neighboring fixtures, in the event a resident emergency evacuation. 2. At 11:25 A.M., the surveyor observed at the egress door identified as # [redacted] that the fixture contained one-bulb and the next rooftop light fixture was approximately 50' away and the surrounding was not provided with enough light in the event a resident emergency evacuation. An interview was conducted with the Maintenance Director at the time of the observations and he stated that he was unaware of this requirement. NJAC 8:39 - 31.2(e) 19.2.9.1 (Emergency Lighting)	K 281	the Statement of Deficiencies (SOD) on or before 5/14 to a double-bulb fixtures, doubling the lumens output. 2.All other exit discharges were audited by the Maintenance Director/ designee on or before 5/14 to ensure proper illumination. Any notable areas were addressed accordingly. 3.On or before 5/14, the regional Director of Plant Operations/Designee will conduct in-service training to the maintenance staff on NFPA 101 proper illuminations at means of egress. 4.Audit to be conducted bi-weekly by the maintenance director/designee on exit discharge illumination to ensure proper illumination. Audit will be conducted for 3 months or until QAPI committee deems appropriate. QAPI committee will meet monthly.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/28/21, in the presence of the Maintenance Director, it was determined that the facility failed to properly identify doors, with a sign, which is neither an exit	K 293	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	5/14/21

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K 293	Continued From page 3 nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall have a "No Exit" sign in accordance with NFPA 101, 2012 Edition, Section 7.10 and 7.10.8.3. The deficient practice was evidenced by the following: 1. At approximately 10:43 A.M., the surveyor observed that the door leading into the enclosed courtyard by room [redacted] did not have a "NO EXIT" sign. 2. At approximately 10:58 AM the surveyor observed that the [redacted]-Center door leading to the [redacted] Center was not an exit and displayed the incorrect sign "NOT AN EXIT". 3. At approximately 11:15 A.M., the surveyor observed that the door in the Medical Records office lead into the courtyard and did not have a "NO EXIT" sign. The findings were verified by the Maintenance Director at the times of the observation's. The Administrator was informed of the deficiency at the Life Safety Code exit conference. NJAC 8:39-31.2(e) I	K 293	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.Areas identified in the Statement of Deficiencies (SOD) as having no-exit, were outfitted with appropriate no-exit signage. This was completed by or before 5/14. Please see attachments. 2.All other areas appropriate for a no-exit sign were reviewed by the maintenance director/designee to ensure proper signage was in place. Anything identified was addressed accordingly. This was completed by or before 5/14. 3.On or before 5/14, the regional Director of Plant Operations/Designee will conduct in-service training to the maintenance staff on NFPA 101, Exit Signage, including the requirement to identify doors which is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall have a no-exit sign. 4.Audit to be conducted bi-weekly by the maintenance director/designee on doors which is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit to ensure that have no-exit sign. Audit will be conducted for 3 months or until QAPI committee deems appropriate. QAPI committee will meet monthly.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321		5/14/21

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K 321	Continued From page 4 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 04/28/21, it was determined that the facility failed to ensure that doors to rooms in excess of 50-square feet and storing combustible items were equipped with with self-closing hardware. This deficient practice was evidenced by the following:	K 321	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	

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K 321	Continued From page 5 1. At 09:54 A.M., during a building tour with the Facility's Maintenance Director, The surveyor observed resident room [redacted] had been converted into a hazardous storage area and was not provided with a self-closure device on the door. The room contained: Tables, 2 mattresses, plastic planter pot and many miscellaneous items. 2. At 09:59 A.M., during a building tour with the Facility's Maintenance Director, The surveyor observed that resident room [redacted] had been converted into a hazardous storage area and was not provided with a self-closure device on the door. The room contained: plastic combustibles, combustible cardboard boxes and many miscellaneous items. 3. At 10:05 A.M., during a building tour with the Facility's Maintenance Director, The surveyor observed resident room [redacted] that had been converted into a hazardous storage area was not provided with a self-closure device on the door. The room contained: PPE storage and 100 plus combustible cardboard boxes. 4. At 10:15 A.M., during a building tour with the Facility's Maintenance Director, The surveyor observed resident room [redacted] had been converted to a hazardous storage area and was not provided with a self-closure device on the door. The room contained: 50 plus combustible cardboard boxes, three reclining chairs and many full plastic bags of miscellaneous items. 5. At 10:25 A.M., during a building tour with the Facility's Maintenance Director, The surveyor observed resident room [redacted] had been converted into a hazardous storage area and was not	K 321	require it. 1.Areas identified in the Statement of Deficiencies (SOD) were outfitted with self-closing hardware on or before 5/10. 2.All other rooms in excess of 50-square feet and storing combustibles were reviewed for appropriate self-closing hardware. Nothing noteworthy identified. 3.On or before 5/14, the regional Director of Plant Operations/Designee will conduct in-service training to the maintenance staff on NFPA 101, Hazardous Area □ Enclosure, including the requirement to have self-closing hardware on all rooms in excess of 50-square feet and storing combustibles. 4.Audit to be conducted bi-weekly by the maintenance director/ designee on all rooms in excess of 50-square feet and storing combustibles to ensure they have self-closing hardware. Audit will be conducted for 3 months or until QAPI committee deems appropriate. QAPI committee will meet monthly.	

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K 321	Continued From page 6 provided with a self-closure device on the door. The room contained: many combustible cardboard boxes, furniture and mattresses. 6. At 10:25 A.M., during a building tour with the Facility's Maintenance Director, The surveyor observed [redacted] Model room had been converted into a hazardous storage area and was not provided with a self-closure device on the door. The room contained: chairs, 4- beds, mattresses, couch and many miscellaneous items. 7. At 10:35 A.M., during a building tour with the Facility's Maintenance Director, The surveyor observed in the storage room across from resident room #1 that was converted into a hazardous storage area was not provided with a self-closure device on the door. The room contained 40 plus plastic combustible garbage cans. An interview was conducted with the Maintenance Director during the observation's and he stated he was unaware of this requirement. The surveyor verbally informed the facility's Administrator of this finding during the Life Safety Code exit conference, NJAC 8:39-31.2(e)	K 321		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		5/23/21

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K 353	Continued From page 7 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/28/21, it was determined that the facility failed to ensure that the building's automatic sprinkler system was maintained in safe condition as evidenced by the following: 1. Automatic sprinkler heads were not free of foreign materials which could prevent or delay their operation. At 12:15 PM, during a tour of the Laundry room in the presence of the facility's Maintenance Director, the surveyor observed 5 of 5 automatic sprinkler heads located in front of the commercial washing machine and clothes dryer area's that had a heavy amount of lint on the sprinkler heads. The facility's Maintenance Director was unaware of this condition and acknowledge such in an interview during the observation. 2. One automatic fire sprinkler head, behind the 3-commercial clothes dryers had paint on the head.	K 353	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.Building sprinkler system areas identified in the Statement of Deficiencies (SOD) as not being maintained in a safe condition were fixed. Please see attachment. a.The sprinkler heads with decay and paint are being replaced by contractor on or before 5/23. b.The penetrations identified in SOD were fixed by the maintenance director/designee on 4/28. c.The North System Gong identified in the SOD was fixed by the fire safety vendor	

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K 353	Continued From page 8 The facility's Maintenance Director was unaware of this condition and acknowledge such in an interview during the observation. 3. In the Activities room a 2' x 2' ceiling tile was missing and a fire sprinkler head was within 4 feet of the area. The opening would now allow hot gasses and smoke past the sprinkler into the space above. The facility's Maintenance Director was unaware of this condition and acknowledged such in an interview during the observation. 4. The facility provided documentation dated 03/11/21 from their Fire Sprinkler vendor. The document indicated under Deficiencies: "[redacted] not working, should be serviced." The facility's Maintenance Director was aware of this condition and indicated that the fire sprinkler vendor was short of manpower and would respond as soon as possible to repair the "[redacted]". The facility's Maintenance Director was verbally informed of this finding during the Life Safety Code exit conference. NFPA 25 NJAC 8:39-31.2(e)	K 353	on 4/28. 2. a.All other sprinklers were audited to ensure their integrity. This was completed on 4/28 by the maintenance staff. b.All areas were audited to ensure there were not any penetrations. Nothing remarkable was noted. This was completed on 4/28 by the maintenance staff. c. All facility sprinkler system was audited, including the gongs, and found to be in good working order. This was completed on 4/28 by the maintenance staff. 3. a.On or before 5/14, the regional Director of Plant Operations/Designee will conduct in-service training to the maintenance staff on maintaining the sprinkler system in good working order, including keeping the sprinkler heads free of debris and dust, keeping the gogs in workable order and ensuring there aren□t any fire-safety penetrations. 4. a.An audit will be conducted the maintenance director/designee monthly on the sprinkler system to review the integrity of all sprinkler heads. Results of these audits will be presented to the QAPI committee who will decide duration of the audits. b.An audit will be conducted by the maintenance director/designee monthly to ensure all ceiling tiles are in place. Results of these audits will be presented to the QAPI committee who will indicate the duration of the audits.	

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K 353	Continued From page 9	K 353	c.The facility sprinkler system, including the gongs, will be audited monthly, for 5 months, to ensure they are in good working order. Results of these findings will be reported to the QAPI committee. The QAPI committee will meet monthly.	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing	K 918		5/14/21

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K 918	Continued From page 10 the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 04/27/21 in the presence of the Maintenance Director, it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10 second timeframe in accordance with NFPA 99 for both emergency electrical generator systems. This deficient practice was evidenced by the following: At 10:30 a.m., a review of the facility's generator testing and inspection documentation for both generators revealed the following: A review of the generator records for the previous 12 months revealed that there was no documented certification that the generator would start and transfer power to the building within 10 seconds. In an interview, at 11:00 a.m., the facility's Maintenance Director stated that there were no documented times on the current logs, indicating the generator would start and transfer power to the building within 10 seconds. NJAC 8:39-31.2(e), 31.2(g) NFPA 99	K 918	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.The generator identified in the Statement of Deficiencies (SOD) was reviewed to ensure that the time needed to transfer power to the facility was within the required 10 second timeframe in accordance with NFPA 99. This was certified by the maintenance director/designee on 4/29. 2.All facility generator systems were inspected to ensure they are in compliance with capability of supplying service within 10 seconds. 3.The maintenance director/designee was provided with in-service education on testing and certifying the facility generator system to ensure it has the capability of supplying service within 10 seconds. This was done by the regional director of plant operations on or before 5/12. 4.The Maintenance Director/designee will review the generator records monthly to ensure that there was documentation	

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K 918	Continued From page 11	K 918	certifying that generator would start and transfer power to the building within 10 seconds. Results will be reported to the QAPI committee for follow up. The committee will determine duration of the audit based on outcomes of the audits. QAPI committee will meet monthly.	