PRINTED: 11/19/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315524	B. WING _			02/	16/2021	
	ROVIDER OR SUPPLIER BROOK REHABILITATION	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	;	FC	000				
	Survey date: 2/16/21							
	Census: 164							
	Sample: 5							
	was conducted by the Health. The facility was with 42 CFR §483.80							
							(//0) D/TT	
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUF	RE	TITLE			(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

02/17/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) I	(X3) DATE SURVEY COMPLETED	
		315524	B. WING			02/16/2021	
NAME OF PROVIDER OR SUPPLIER LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COI 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 000	Continued From pa	nge 1	FO				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) D	(X3) DATE SURVEY COMPLETED	
		315524	B. WING			02/16/2021	
NAME OF PROVIDER OR SUPPLIER LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COI 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 000	Continued From pa	nge 2	FO				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		315524	B. WING _			02/16/2021	
	ROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 000	Continued From page		FO				
	Survey date: 2/16/2	1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315524	B. WING _			02/ ⁻	16/2021
NAME OF PROVIDER OR SUPPLIER LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054	DE.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA		(X5) COMPLETION DATE
F 000	Continued From page	e 4	F 0	00			
	Sample: 5						
	was conducted by the Health. The facility wa with 42 CFR §483.80						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) C	(X3) DATE SURVEY COMPLETED	
		315524	B. WING			02/16/2021	
NAME OF PROVIDER OR SUPPLIER LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COE 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 000	Continued From pa	nge 5	FO				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		315524	B. WING			02/16/2021	
NAME OF PROVIDER OR SUPPLIER LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COI 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 000	Continued From pa	ge 6	FO				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315524	B. WING		02/16/2021
NAME OF PROVIDER OR SUPPLIER LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054	·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 000	Continued From page	÷7	F 000		
	Survey date:				
	Census: Sample:				
	was conducted by the Health. The facility wa with 42 CFR §483.80				