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 06/01/2023

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		
F 000	INITIAL COMMENTS Complaint NJ #: 156618; 159650; 160150; 160664; 161353; 161540 Survey Date: 6/1/23 Census:196 Sample: 35 + 5 + 2 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.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		6/12/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 06/16/2023

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.

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F 609	Continued From page 1 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) an allegation of NJ Exec Order 26.4b1 between Resident #72 and #146 that occurred on NJ Exec Order 26. This deficient practice was identified for 1 of 2 reportable investigations reviewed, and was evidenced by the following: On 5/22/23 at 12:28 PM, the surveyor observed Resident #72 sitting in their room. Resident #72 informed the surveyor that on NJ Exec Order 26.4b1 he/she was involved in a NJ Exec Order 26.4b1 " with their roommate (Resident #146). Resident #72 reported that Resident #146 was speaking with their Nurse Practitioner (NP), and the NP asked Resident #146 a question, which the resident did not respond so he/she (Resident #72) answered the NP's question. Resident #72 continued that	F 609	F609 Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) 483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: 483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance	

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F 609	Continued From page 2 Resident #146 became NJ Exec Order that he/she was NJ Exec Order 26.4b1 occurred. Resident #72 stated multiple staff were involved to NJ Exec Order 26.4b1, and a Certified Nursing Aide (CNA) NJ Exec Order 26.4b1, and stated the CNA saw that NJ Exec Order 26.4b1 coming. Resident #72 reported that Resident #146 was moved that day. The surveyor reviewed the medical record for Resident #72. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in NJ Exec Order 26.4b1, with diagnoses which included NJ Exec Order 26.4b1 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26, reflected a brief interview for mental status (BIMS) score of NJ Exec out of 15, which indicated a NJ Exec Order 26.4b1. A review of the Progress Notes did not include the incident from NJ Exec Order 26. The surveyor reviewed the medical record for Resident #146. A review of the Admission Record face sheet reflected the resident was admitted to the facility in NJ Exec Order 26.4b1, with diagnoses which included NJ Exec Order 26.4b1.	F 609	with State law through established procedures. 483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 1. Residents # 72 & 146 were evaluated and had NJ Exec Order 26.4b1 The incident was reported to the NJ Department of Health on NJ Exec O. Investigation was conducted and the completed summary and conclusion was emailed to the NJ Department of Health on NJ Exec Order 26.4b1 2. All cases of residents with allegations of abuse, neglect or misappropriation have the potential to be affected by this deficient practice. The NHA audited all cases of residents with allegations and abuse, neglect, or misappropriation to assure that identified cases were reported timely to the state licensing agency. 3. The DON/designee re-educated the interdisciplinary team, Nurses, and CNAs on the “Abuse, Neglect, Exploitation or Misappropriation”. This focuses on the facility’s responsibility to ensure alleged violations involving misappropriation, neglect, and/or abuse are immediately reported to the Administrator and respective state agencies as indicated. 4. The NHA/designee will audit incident reports, grievances and investigations daily X5 weekly x4 and monthly x3 to ensure all allegations of	

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F 609	Continued From page 3 A review of the admission MDS dated NJ Exec Order, reflected a BIMS score of NJ Exec out of 15, which indicated a NJ Exec Order 26.4b1 A review of the Progress Notes did not include the incident from NJ Exec Order 26.4b On 5/23/23 at 10:49 AM, the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) provided the surveyor with all investigations for Resident #72 since their admission. This did not include the NJ Exec Order 26.4b1 incident on NJ Exec Order 26 On 5/23/23 at 12:32 PM, the surveyor interviewed Resident #146 who stated their room was changed on NJ Exec Order 26, after an incident with NJ Exec O (Resident #72). Resident #146 stated they were speaking with their NP and Resident #72 jumped into their conversation and Resident #72 started NJ Exec Order and NJ Exec Order 26.4b1 at me, and NJ Exec Order 26.4b1 Resident #146 stated every time I am speaking to someone, Resident #72 inserted themself into the conversation to speak on my behalf. Resident #146 continued on NJ Exec Order 26, Resident #72 started NJ Exec Order 26.4b1 and staff packed up my belongings and moved me. Resident #146 stated the NJ Exec Order 26.4b1 was only NJ Exec Order 2 that no one was NJ Exec Order 26, but he/she was very NJ Exec Orde at the time by the NJ Exec Order 26.4b1 On 5/24/23 at 8:33 AM, the surveyor asked the DON if the facility investigated the incident that occurred on NJ Exec Order 26 between Resident #72 and #146, and the DON stated she would have to	F 609	abuse/neglect/misappropriation origin are reported timely. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director. 5. Date when corrective action will be completed: June 12, 2023.	

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F 609	Continued From page 4 check. On 5/24/23 at 8:41 AM, the DON informed the surveyor there was no investigation for that day. The surveyor then asked if the DON was aware of an incident between Resident #72 and #146 that day, and the DON stated no. The surveyor informed the DON what both residents had informed them, and that they were both NJ Exec Ord and NJ Exec Order 26.4b1 by staff as well as Resident #146's NJ Exec Order 26.4b1. The DON stated she was unaware of the of the situation, but there should have been a Progress Note and an investigation should have been started because it was NJ Exec Order 26.4b1 On 5/24/23 at 8:48 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated investigations were conducted by unit managers, supervisors, and the DON for incidents that included allegations of NJ Exec Order 26.4b1 The surveyor asked the UM/LPN about the incident that occurred on NJ Exec Order 26, and the UM/LPN stated she was in a care conference meeting and when she returned to the unit, the NP and multiple staff were in Resident #72 and #146's room. The DON stated that Resident #146 requested NJ Exec Order 26.4b1, and she thought nothing of it because a few weeks ago Resident #72 complained about NJ Exec Order 26.4b1 and was offered NJ Exec Order 26.4b1 and Resident #72 declined. The UM/LPN stated she spoke to staff and knew there was an NJ Exec Order 26.4b, and NJ Exec Orde . The UM/LPN stated there were at least ten staff members present in the room at the time which included the NP, CNAs, and housekeeping staff. The UM/LPN confirmed there was no documented Progress	F 609		

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F 609	Continued From page 5 Note about the incident and there should have been documentation as well as an investigation. On 5/24/23 at 11:58 AM, the surveyor interviewed the DON who stated the facility investigated all allegations o NJ Exec Order 26.4b1 The DON stated all allegations of NJ Exec Orde were reported to the NJDOH immediately, investigated, and then a conclusion was reported. The DON confirmed it was not investigated or reported. On 6/1/23 at 9:56 AM, the LNHA in the presence of the DON, Regional Director of Clinical Services, and the survey team acknowledged that the incident was not reported to the NJDOH prior to surveyor inquiry. A review of the facility's "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" policy dated revised September 2022, included all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by regulations) and thoroughly investigated by facility management...The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility..."immediately" is defined as within two hours of an allegation involving abuse or result in serious bodily injury... NJAC 8:39-9.4(f)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation	F 610		6/12/23

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F 610

Continued From page 6
CFR(s): 483.12(c)(2)-(4)

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to investigate a.) an incident of NJ Exec Order 26.4b1 for Resident #72 and #146 on NJ Exec Order 26, and b.) an incident with a resident sent to the emergency department with a NJ Exec Order 26.4b1 on NJ Exec Order. This deficient practice was identified for 2 of 3 residents reviewed for NJ Exec Order 26.4b1 (Resident #72 and #189), and was evidenced by the following:

1. On 5/22/23 at 12:28 PM, the surveyor observed Resident #72 sitting in their room. Resident #72 informed the surveyor that on NJ Exec Order 26.4b1 he/she was involved in a NJ Exec Order 2

F 610

F610 Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)
483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: 483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. 483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. 483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified

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F 610	Continued From page 7 NJ Exec Order 26.4b1 " with NJ Exec O (Resident #146). Resident #72 reported that Resident #146 was speaking with their Nurse Practitioner (NP), and the NP asked Resident #146 a question, which the resident did not respond so he/she (Resident #72) answered the NP's question. Resident #72 continued that Resident #146 became NJ Exec Ord that he/she was speaking on their behalf to their NP, and a NJ Exec Order 26.4b1 occurred. Resident's #72 stated multiple staff were involved to NJ Exec Order 26.4b1, and a Certified Nursing Aide (CNA) NJ Exec Order 26.4b1 and stated the CNA stated she saw that NJ Exec Order 26.4b1 coming. Resident #72 reported that Resident #146 was moved that day. The surveyor reviewed the medical record for Resident #72. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in NJ Exec Order 26.4b1, with diagnoses which included NJ Exec Order 26.4b1 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26, reflected a brief interview for mental status (BIMS) score of NJ Exec out of 15, which indicated a NJ Exec Order 26.4b1. A review of the Progress Notes did not include the incident from NJ Exec Order 26. The surveyor reviewed the medical record for Resident #146.	F 610	appropriate corrective action must be taken. 1. All residents still reside in the facility and both cases were fully investigated. Residents #72 and #146, the Summary and Conclusion was submitted to the Department of Health on NJ Exec Order 26.4b1 Resident #189 still resides in the facility, the case was fully investigated, and resident is currently at baseline. 2. All cases of residents with allegations of abuse, neglect or misappropriation have the potential to be affected by this deficient practice. The NHA audited all cases of residents with allegations and abuse, neglect, or misappropriation to assure that identified cases were investigated timely. 3. The DON/designee re-educated the interdisciplinary team and all licensed staff on the investigation for Abuse, Neglect, Exploitation or Misappropriation. 4. The NHA/designee will audit incident reports, grievances and hospitalizations to ensure all allegations of abuse/neglect/misappropriation are investigated, daily X5 weekly x4 and monthly x3. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director. 5. Date when corrective action will be completed: June 12, 2023.	

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F 610	Continued From page 8 A review of the Admission Record face sheet reflected the resident was admitted to the facility in NJ Exec Order 26.4b1, with diagnoses which included NJ Exec Order 26.4b1 A review of the admission MDS dated NJ Exec Order 2, reflected a BIMS score of NJ Exec out of 15, which indicated a NJ Exec Order 26.4b1. A review of the Progress Notes did not include the incident from NJ Exec Order 26.4b On 5/23/23 at 10:49 AM, the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) provided the surveyor with all investigations for Resident #72 since their admission. This did not include the NJ Exec Order 26.4b1 incident on NJ Exec Order 26 On 5/23/23 at 12:32 PM, the surveyor interviewed Resident #146 who stated their room was changed on NJ Exec Order 26, after an incident with NJ Exec Or (Resident #72). Resident #146 stated they were speaking with their NP and Resident #72 jumped into their conversation and Resident #72 started NJ Exec Order 26.4b1 at me, and NJ Exec Order 26.4b1 Resident #146 stated every time I am speaking to someone, Resident #72 inserted themself into the conversation to speak on my behalf. Resident #146 continued on NJ Exec Order 26, Resident #72 started NJ Exec Order 26.4b1" and staff packed up my belongings and moved me. Resident #146 stated the NJ Exec Order 26.4b1 was only NJ Exec Order 2 that no one was NJ Exec Order 26.4b, but was very	F 610		

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F 610	Continued From page 9	F 610		

NJ Exec Order at the time by the NJ Exec Order 26.4b1.

On 5/24/23 at 8:33 AM, the surveyor asked the DON if the facility investigated the incident that occurred on NJ Exec Order 26 between Resident #72 and #146, and the DON stated she would have to check.

On 5/24/23 at 8:41 AM, the DON informed the surveyor there was no investigation for that day. The surveyor then asked if the DON was aware of an incident between Resident #72 and #146 that day, and the DON stated no. The surveyor informed the DON what both residents had informed them, and that they were both NJ Exec Order and NJ Exec Order 26.4b1 by staff as well as Resident #146's NJ Exec Order 26.4b1. The DON stated she was unaware of the of the situation, but there should have been a Progress Note and an investigation should have been started because it was NJ Exec Order 26.4b1.

On 5/24/23 at 8:48 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated investigations were conducted by unit managers, supervisors, and the DON for incidents that included allegations of NJ Exec Order 26.4b1 The surveyor asked the UM/LPN about the incident that occurred on NJ Exec Order 26.4b and the UM/LPN stated she was in a care conference meeting and when she returned to the unit, the NP and multiple staff were in Resident #72 and #146's room. The DON stated that Resident #146 requested a NJ Exec Order 26.4b1, and she thought nothing of it because a few weeks ago Resident #72 complained about NJ Exec Order 26.4b1 and was offered NJ Exec Order 26.4b1 and Resident #72 declined. The UM/LPN stated she spoke to staff

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F 610	Continued From page 10 and knew there was an NJ Exec Order 26.4b1, and NJ Exec Orde The UM/LPN stated there were at least ten staff members present in the room at the time which included the NP, CNAs, and housekeeping staff. The UM/LPN confirmed there was no documented Progress Note about the incident and there should have been documentation as well as an investigation. On 5/24/23 at 11:58 AM, the surveyor interviewed the DON who stated the facility investigated all allegations o NJ Exec Order 26.4b1 The DON stated that initially it was reported that the NJ Exec Order 26.4b1, and it was not until surveyor inquiry did they realize it should have been investigated. The surveyor asked the DON if the UM/LPN stated there was ten staff members present in a room, that something possibly happened that should be investigated, and the DON confirmed it should have been. On 6/1/23 at 9:56 AM, the LNHA in the presence of the DON, Regional Director of Clinical Services, and the survey team acknowledged that the incident was not investigated and should have been until surveyor inquiry. The LNHA stated all staff involved were educated on NJ Exec Orde prior to this incident. 2. On 5/22/23 at 9:12 AM, the surveyor observed Resident #189 sitting in bed eating breakfast. The surveyor reviewed the medical record for Resident #189.	F 610		

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(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 610	Continued From page 11 A review of the Admission Record face sheet reflected that the resident was admitted to the facility in NJ Exec Order 26.4b1 with a readmission date of NJ Exec Order 26.4b1, with diagnoses which included NJ Exec Order 26.4b1 A review of the most recent quarterly MDS dated NJ Exec Order 26 reflected a BIMS score of NJ Ex out of 15, which indicated a NJ Exec Order 26.4b1. Further review revealed that the resident required for Activities of Daily Living (ADLS) extensive assistance with one person assist for NJ Exec Order 26.4b and was frequently NJ Exec Order 26.4b1 A review of the Progress Notes (PN) reflected a Health Status Note dated NJ Exec Order 26 at 4:47 AM, that the resident was admitted to the hospital with a diagnosis of NJ Exec Order 26.4b1 A review of the After Visit Summary (discharge instructions) from the hospital with a printed date of NJ Exec Order, included a summary of the hospital course reflected that the resident was in the hospital for NJ Exec Order 26.4b1 and was found to have NJ Exec Order 26.4b1. The resident had a NJ Exec Order 26.4b1 was seen by a NJ Exec Order 26.4b1 and had a NJ Exec Order 26.4b1	F 610		

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	315524	A. BUILDING ______ B. WING ______	C 06/01/2023

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F 610	Continued From page 12 NJ Exec Order 26.4b1 The resident was placed on an NJ Exec Order 26.4b1 and had marked NJ Exec Order 26.4b1 after having a NJ Exec Order 26.4b1 A review of the PN included a Nurse Practitioner Note (NPN) dated NJ Exec Order 2 at 6:37 PM, that the reason for the visit being NJ Exec Order 26.4b1 that the resident was sent to the emergency department (ED) for NJ Exec Order 26.4b1. A NJ Exec Order 26.4 was performed at the hospital and revealed a NJ Exec Order 26.4b1 The resident was manually NJ Exec Order 26.4b1 in the ED, and on NJ Exec Order 26 the resident had a NJ Exec Order 26.4b1; the finding include NJ Exec Order 26.4b1 On 5/23/23 at 12:43 PM, the surveyor interviewed the Director of Nursing (DON), who stated that the resident had a NJ Exec Order 26.4b1, and an NJ Exec Order 26.4b1 was considered a NJ Exec Order 26.4b1 The DON further stated that the facility should have completed an investigation. On 5/24/23 at 10:12 AM, the surveyor interviewed the Nurse Practitioner (NP) who stated that the resident had NJ Exec Order 26.4b1 with NJ Exec Orde. The resident was NJ Exec Order 26.4b1 due to a NJ Exec Order 26.4b1. The NP stated that the resident had NJ Exec Order 26.4b1 (which could be a	F 610		

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F 610	Continued From page 13 result of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1, so he/she was sent to the ED. The NP further stated that the NJ Exec Order 26.4 had been performed in the ED. On 5/24/23 at 11:45 AM, the surveyor interviewed Resident #189 who stated they had sudden NJ Exec Order 26.4b1 and had NJ Exec Order 26.4b1 at the facility and was sent to the ED. The resident further stated that they were admitted to the hospital with NJ Exec Order 26.4b1. On 5/31/23 at 12:45 PM, the surveyor interviewed the DON in the presence of the Licensed Nursing Home Administrator (LNHA). The DON confirmed the resident had NJ Exec Order 26.4b1 and should have completed an investigation. A review of the facility's undated "Accident and Incidents - Investigating and Reporting" policy included all incidents and accidents involving residents, employees, visitors, vendors, [etcetera], occurring on our premises shall be investigated and reported to the administrator. The nurse supervisor/charge nurse and/or department director or supervisor shall promptly initiate and document investigation of the accident or incident... A review of the facility's "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" policy dated revised September 2022, included all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and	F 610		

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F 610	Continued From page 14 reported...The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility..."immediately" is defined as within two hours of an allegation involving abuse or result in serious bodily injury... NJAC 8:39-4.1(a)5; 27.1(a)	F 610		
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: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) administer medications according to physician's orders; b.) clarify a physician's order; and c.) contact the pharmacy and physician for a medication (vitamin E) that was unavailable in accordance with professional standards of practice. This deficient practice was identified for 1 of 3 residents observed for medication administration (Resident #282), and was evidenced as follows: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case	F 658	F658 Services Provided Meet Professional Standards 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. 1. Residents # 282 were evaluated and had no ill effect from the deficient practice. The resident was assessed, the physician was notified, new orders received and implemented. Resident was discharged on NJ Exec Order 26.4b1 2. All residents have the potential to be affected by this deficient practice. DON audited all residents MARs/TARs to	6/12/23

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F 658	Continued From page 15 finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 5/18/23 at 8:10 AM, the surveyor observed the Licensed Practical Nurse (LPN) preparing to administer medications to Resident #282. The surveyor observed the LPN NJ Exec Order 26.4b1 into a medication cup. At that time, the surveyor asked the LPN to review the Medication Administration Record (MAR). The MAR reflected a physician's order (PO) dated NJ Exec Order 26, for NJ Exec Order 26.4b1 give one capsule by mouth one time a day for NJ Exec Order 26.4b1 The LPN and surveyor reviewed the label on the bottle of NJ Exec Order 26.4b1 which indicated each tablet of NJ Exec Order 26.4b1 was NJ Exec Order 26.4 The LPN acknowledged that she should have contacted the physician to clarify the above order. 2. On that same date and time, the LPN and surveyor reviewed the MAR and observed a PO dated NJ Exec Order 26, for NJ Exec Order 26.4b1 by mouth one time a day. The LPN stated, "the medication is still not available." The surveyor asked the LPN how long it had not been available. The LPN replied that it had not been available for the past three, days so she was not able to administer it. The surveyor asked the LPN if she had contacted the pharmacy or the physician, and the LPN replied, " no." The LPN acknowledged she should have contacted the pharmacy. At that time, the LPN called the pharmacy who informed her the NJ Exec Order 26.4b was not available in NJ Exec Order 26.4b1. Further	F 658	identify any medications that were not available and to assure if medication was available in back up supply and physician was notified of any medications not available and if substitution was required. 3. The Director of Nursing will re-educate all nurses on the Unavailable Medication process, physician notification and required documentation. 4. The DON/designee will audit all Medication Administration Records to assure all medications are available for administration. Daily x5 weekly x4 and monthly X 3. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director. 5. Date when corrective action will be completed: June 12, 2023.	

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F 658	Continued From page 16	F 658		

review of the MAR revealed the LPN signed that the medication had been administered on NJ Exec Order 26 and NJ Exec Order 26. The LPN stated she should not have signed the MAR indicating that she had administered the medication when she had not. The LPN acknowledged that she should have contacted the pharmacy on NJ Exec Order 26, when she first identified the medication was not available.

The surveyor reviewed the medical record for Resident #282.

A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in NJ Exec Order 26.4b1, with diagnoses which included NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

A review of the admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26 reflected that the resident had a brief interview for mental status (BIMS) score of NJ E out of 15, which indicated an NJ Exec Order 26.4b1.

A review of the Order Summary Report included a PO dated NJ Exec Order 26, for NJ Exec Order 26.4b1 ; give one capsule by mouth one time a day, and a PO dated NJ Exec Order 26, for NJ Exec Order 26.4b1 by mouth one time a day for NJ Exec Order 26.4b1

A review of the Progress Notes dated NJ Exec Order 26 to NJ Exec Order 26, did not indicate that the LPN had notified the pharmacy or the physician regarding the unavailability of the NJ Exec Order 26.4b1 or the clarification of the NJ Exec Order 26.4b1.

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F 658	Continued From page 17 On 5/31/23 at 9:12 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the LPN should have checked the physician's orders with the medication label prior to administering the NJ Exec Order 26.4b1 to ensure she was administering the medication as per the physician's order. The DON acknowledged that the LPN should have called the resident's primary care physician to clarify the order if the facility only had NJ Exec Order 26.4b1 capsules and not NJ Exec Order 26 capsules. The DON stated the LPN should have contacted the pharmacy on the first day that the NJ Exec Order 26.4b1 was not available. On 6/1/23 at 9:56 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and Regional Director of Clinical Services to discuss the above concerns. The DON acknowledged the LPN's errors and stated that the LPN should not have signed the MAR indicating she had administered a medication (NJ Exec Order 26.4b) that was not available to be administered. A review of the facility's undated "Medication Administration Observation Worksheet" policy included...the nurse administering the medications was to check the medication container label with the MAR, administer the medications exactly as ordered and administer the dose exactly as ordered... NJAC: 8:39-29.2(d)	F 658		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management.	F 697		6/12/23

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F 697	Continued From page 18 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Complaint NJ #160150 Based on interview, closed medical records, and review of pertinent facility documents, it was determined the facility failed to a.) assess and document the resident's NJ Exec Order 26.4b ; b.) document the administration of an as needed NJ Exec O ; and c.) re-evaluate and document the effectiveness of NJ Exec Order 26.4b1 in accordance with professional standards of practice. This deficient practice was identified 1 of 3 residents reviewed for NJ Exec Order 26.4b1 (Resident #435), and was evidenced by the following: On 5/17/23 at 11:35 AM, the surveyor reviewed the closed medical record for Resident #435. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in NJ Exec Order 26.4b1 , with diagnoses which included NJ Exec Order 26.4b1 A review of the admission Minimum Data Set	F 697	F697 Pain Management CFR(s): 483.25(k) 483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. 1. Resident #435 no longer resides in the facility. 2. All residents have the potential to be affected by this deficient practice. DON audited all residents MARs/TARs to ensure that residents with pain were assessed, pain level was documented, pain medication was administered and documented, and resident's pain was reassessed for effectiveness and documented. 3. The Director of Nursing re-educated all nurses on pain assessment, pain level documentation, pain medication administration and documented and resident's pain reassessed for effectiveness and documented. 4. The DON/designee will audit all Medication Administration, Daily x5 weekly x4 and monthly X 3. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and	

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F 697	Continued From page 19 (MDS), an assessment tool dated NJ Exec Order 26.4b, reflected the resident had a brief interview for mental status (BIMS) score NJ Exec out of 15, which indicated a NJ Exec Order 26.4b1. A further review indicated the resident received routine scheduled NJ Exec Order 26.4b1 and as needed NJ Exec O in the last five days with frequent NJ Exec O that NJ Exec Order 26.4b1 with an intensity from NJ Exec Order 26.4b1 A review of the individualized comprehensive care plan (ICCP) included a focus area dated NJ Exec Order 26, for I have NJ Exec Order 26.4b1 Interventions included to administer NJ Exec Order 26.4b1) as per orders, observe for effectiveness and signs and symptoms of side effects; anticipate my need for NJ Exec Order 26.4b1 and respond to reports and signs and symptoms of NJ Exec O; encourage me to non-pharmacological interventions for NJ Exec O NJ Exec. O as applicable; evaluate effectiveness of NJ Exec O interventions; monitor and record the presence of NJ Exec O every shift and as needed. A further review of the ICCP included a focus area dated NJ Exec Order 26, for I am on NJ Exec Order 26.4b1. Interventions included to administer medication as ordered and monitor for effectiveness and adverse effects; monitor for NJ Exec Order 26.4b1 ..observe for adverse reactions with every interaction with the resident; monitor safety due to potential increased risk for NJ Exec O; and NJ Exec Order 26.4b1 can rapidly reverse NJ Exec Order 26.4b1, have available in case of emergency. A review of the Order Summary Report with a	F 697	Medical Director. 5. Date when corrective action will be completed: June 12, 2023.	

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F 697	Continued From page 20 date range of NJ Exec Order 26 to NJ Exec Order 26, included the following physician's orders (PO): A PO dated NJ Exec Order 26, NJ Exec Order 26.4b1 every shift (NJ Exec Order 26.4b1) every shift for NJ Exec O A PO dated NJ Exec Order 26 NJ Exec Order 26.4b1 tablet, an NJ Exec Order 26.4b1 medication; give NJ Exec Order 26 by mouth every four hours as needed for NJ Exec Order 26.4b1 of NJ Exec Orde A PO dated NJ Exec Order 26 NJ Exec Order 26.4b1 tablet; give one tablet every four hours as needed for NJ Exec Order 26.4b1. A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) reflected on NJ Exec Order 26, the resident had a documented NJ Exec O for the day shift (7:00 AM to 3:00 PM) and the evening shift (3:00 PM to 11:00 PM). A review of the corresponding administration of NJ Exec Order 26.4b1 for NJ Exec Order 26, revealed the resident only received NJ Exec Order 26.4b1 during the evening shift at 9:30 PM for a NJ Exec Order 26.4b1 that was effective. There was no documentation that NJ Exec Order 26.4b1 was administered per PO during the day shift on NJ Exec Order 26 where the nurse documented a NJ Exec Order 26.4b1 for that shift. A review of the Progress Notes, included a Nurse Practitioner Note dated NJ Exec Order 26 at 2:58 PM, that the resident was admitted to the facility from the hospital NJ Exec Order 26.4b1 The resident was seen today for NJ Exec Order 26.4b1 and upon examination, resident	F 697		

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F 697	Continued From page 21	F 697		

reported NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and had not received medications yet. There were no documented Nurse's Notes at this time for the resident's NJ Exec O.

On 5/17/23 at 1:00 PM, the surveyor requested from the Director of Nursing (DON) a list of all medications in their back-up supply system.

On 5/18/23 at 7:50 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with the facility's back-up medication supply list which included NJ Exec Order 26.4b1

On 5/18/23 at 8:56 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) from NJ Exec Order 26, who stated she was an Agency staff nurse who worked both the day and evening shifts on NJ Exec Order 26 The LPN stated Resident #435 was in a NJ Exec Order 26.4b1 prior to admission to the facility and he/she NJ Exec Order 26.4b1. The LPN stated the initial PO for NJ Exec Order 26.4b1 was a "weird number" NJ Exec Order 26.4b1) from NJ Exec Order 26.4b1, and the pharmacy had not delivered the medication and that dosage was not in the back-up system, so she had spoken to the Nurse Practitioner (NP) who changed the PO. The LPN continued that the resident received NJ Exec Order 26.4b1, that she recalled two facility nurses accessed the back-up medication system for her to obtain the NJ Exec Order 26.4b1 The LPN stated the resident always received their NJ Exec Order 26.4b1, and the resident knew when it was time for their medication and asked for it. The LPN stated NJ Exec Order 26.4b1 was administered to the resident based on the NJ Exec O and the corresponding PO; the nurse

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documented the NJ Exec Order 26.4b1 on the MAR, administered the medication, and then documented the effectiveness in a follow-up. If the medication was not effective, the nurse wrote a Progress Note. The LPN stated she must not have documented on the MAR the NJ Exec Order 26.4b1 received from the back-up system because there was no delay in the resident receiving their NJ Exec Order 26.4b1.

On 5/18/23 at 9:30 AM, the surveyor requested from the LNHA all the declining inventory sheets for Resident #435's NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1

On 5/18/23 at 12:00 PM, the DON provided the declining inventory sheets and stated the facility had not received the resident's NJ Exec Order 26.4b1 tablets until NJ Exec Order 26.4b at 5:00 AM. At this time, the surveyor requested any documentation for NJ Exec Order 26.4b1 removed from the back-up medication system for the resident on NJ Exec Order 26.

On 5/22/23 at 11:43 AM, the DON stated the nurse removed NJ Exec Order 26.4b1 tablets (to equal NJ Exec Order 2 from the back-up system at 12:24 PM, and she removed NJ Exec Order 26.4b1 tablets (to equal NJ Exec Order) at 9:30 PM on NJ Exec Order 26 The DON continued the LPN signed the MAR for the NJ Exec Order 26 at 9:30 PM dose, but she did not sign for the 12:24 PM dose. The DON stated it was acceptable for the nurse to remove NJ Exec Order 26.4b tablets and NJ Exec Order 26.4b1 tablets to equal NJ Exec Order 2 and the number of tablets did not have to be the same as the PO, as long as the dosage was correct without obtaining a one-time order from the physician.

During a follow-up interview on 5/22/23 at 11:58

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(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 697	Continued From page 23 PM, the DON stated the process for administering NJ Exec Order 26.4b1 was the nurse first completed a NJ Exec Order 26.4b1, and then administered medications based on the NJ Exec O and the corresponding PO. The DON continued the nurse then completed a follow-up assessment within thirty minutes to one hour to assess the effectiveness of the NJ Exec Order 26.4b1 and documented that on the MAR. The DON confirmed there should have been documentation for the NJ Exec Order 26.4b1 administered on NJ Exec Order 26 at 12:24 PM, which included the NJ Exec Order 26.4b, administration, and the effectiveness of the medication. The DON stated she could not speak to the effectiveness of the medication because there was no documentation. On 5/23/23 at 10:51 AM, the surveyor interviewed via telephone the resident's NP who stated the resident was admitted to the facility after a NJ Exec Orde and was in NJ Exec Order 26.4b1 The NP stated the resident was admitted with the hospital's recommendation for NJ Exec Order 26 dose of NJ Exec Order 26.4b1, but the dosage was changed to NJ Ex based on the resident's complaint of NJ Exec Order 26.4b The NP stated the resident complained of NJ Exec Order 26.4b1, but reported relief with the NJ Exec Order 26.4b1 tablets. The surveyor asked if there was a time the resident did not receive their NJ Exec Order 26.4b1, and the NP stated when the resident first arrived at the facility, the facility had difficulty obtaining the NJ Exec O dosage since it was not in their back-up system, so she changed the order to NJ Exec Orde tablets to obtain from the back-up system. On 6/1/23 at 9:56 AM, the DON in the presence of the LNHA, Regional Director of Clinical Services, and survey team acknowledged the	F 697		

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	315524	A. BUILDING ______ B. WING ______	C 06/01/2023

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F 697	Continued From page 24 resident's NJ Exec Order 26.4b1 was not documented as being administered and there was no follow-up documentation to determine if the NJ Exec O was effective. A review of the facility's undated "Pain Assessment and Management" policy included...implementing pain management strategies...implement the pain medication regimen as ordered, carefully documenting the results of the interventions...monitoring and modifying approaches: re-assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in level of chronic pain...documentation: document the resident's reported level of pain with adequate detail enough information to gauge the status of pain and the effectiveness of interventions for pain as necessary and in accordance with the pain management program... NJAC 27.1(a)	F 697		
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, and review of pertinent facility documents, it was determined that the facility failed to ensure all medications were administered without an error of 5% or more. During the medication observation on 5/18/23, the surveyor observed three (3) nurses	F 759	F759 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 its483.45(f)(1) Medication error rates are not 5 percent or greater;	6/12/23

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F 759	Continued From page 25 administer medications to three (3) residents. There were 30 opportunities, and two (2) errors were observed which calculated a medication administration error rate of 6.6%. This deficient practice was identified for one (1) of three (3) residents (Resident #282) that were administered medications by one (1) of three (3) nurses. The deficient practice was evidenced as follows: On 5/18/23 at 8:10 AM, the surveyor observed the Licensed Practical Nurse (LPN) preparing to administer twenty-two (22) oral medications to Resident #282 which included three (3) tablets of NJ Exec Order 26.4b1 tablets and one (1) tablet of NJ Exec Order 26.4b1 On 5/18/23 at that same time, the surveyor observed the LPN enter Resident #282's room to administer the medications. The surveyor asked the LPN to hold the medications and to step outside the room. Upon returning to the medication cart, the surveyor reviewed the Medication Administration Record (MAR) with the LPN. The MAR revealed a physician's order (PO) for NJ Exec Order 26.4b1 tablet; give three (3) tablets by mouth one time a day and a PO for NJ Exec Order 26.4b1; give one (1) tablet by mouth one time daily. The LPN stated that she thought the NJ Exec Order 26.4b she prepared to administer was the correct dosage and further stated that she did not realize that there were two different bottles of NJ Exec Order 26 in the cart. The surveyor with the LPN, reviewed the facility's over the counter (OTC) house stock medications which included a bottle labeled NJ Exec Order 26.4b1 tablets. The LPN confirmed she did not have NJ Exec Order 26 tablets in the	F 759	1. Residents # 282 was not affected by the deficient practice. Resident was assessed, physician was notified, new orders received and implemented. Resident was discharged to home on NJ Exec Order 26.4b1. The LPN was immediately re-educated on the 5 rights of medication administration and Medication Competency was completed. 2. All residents have the potential to be affected by this practice. 3. The Director of Nursing re-educated all nurses on the 5 Rights of medication administration. 4. The DON/designee will complete Medication Administration Competency observation daily x5 weekly x4 and monthly X 3. Results of the audits will be reviewed Monthly with QAPI until substantial compliance is met. The QAPI Committee consists of the NHA, DON and Medical Director. 5. Date when corrective action will be completed: June 12, 2023.	

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F 759	Continued From page 26 cart and therefore should have called the physician to clarify the order. Further review of the OTC house stock medications revealed a bottle labeled NJ Exec Order 26.4b1 and a bottle labeled NJ Exec Order 26.4b1. The LPN stated that she did not realize the two medications were not the same. (ERROR#1 & #2) The surveyor reviewed the medical record for Resident #282. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in NJ Exec Order 26.4b1, with diagnoses which included NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. A review of the admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26, reflected that the resident had a brief interview for mental status (BIMS) score of NJ Ex out of 15, which indicated an NJ Exec Order 26.4b1 A review of the Order Summary Report included a PO dated NJ Exec Order 26 for NJ Exec Order 26.4b1 tablet; give three (3) tablets by mouth one (1) time a day and a PO dated NJ Exec Order 26 for NJ Exec Order 26; give one (1) tablet by mouth a day. On 5/31/23 at 9:12 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the LPN should have checked the physician's orders with the medication label prior to administering the medications to ensure accuracy. On 6/1/23 at 9:56 AM, the survey team met with	F 759		

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F 759	Continued From page 27 the Licensed Nursing Home Administrator (LNHA), DON, and Regional Director of Clinical Services to discuss the above concerns. The DON acknowledged the LPN's errors and stated that the LPN was a new nurse and would be re-educated on the facility's policy for the administration of medications. A review of the facility's undated "Medication Administration Observation Worksheet" policy included...the nurse administering the medications was to check the medication container label with the MAR, administer the medications exactly as ordered and administer the dose exactly as ordered... NJAC 8:39-11.2(b); 29.2(d)	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		6/12/23

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F 761	Continued From page 28 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to a.) maintain medication storage rooms free of expired nutritional formula (Jevity 1.5 calorie) for 1 of 3 medication storage rooms inspected (North 1), and b.) ensure the required Federal narcotic acquisition forms (DEA 222 form) were completed with sufficient detail to enable accurate reconciliation for 2 of 8 forms reviewed. The deficient practice was evidenced by the following: 1. On 5/25/23 at 12:13 PM, in the presence of the Unit Manager/Licensed Practical Nurse (UM/LPN), the surveyor inspected the inventory and medications in North 1 Medication Room. The surveyor observed twenty-three (23) eight-ounce (8 oz) cartons of Jevity 1.5 calorie with the expiration date of 4/1/23. At this time, the UM/LPN confirmed that the formula was expired and should not be in active supply. The UM/LPN confirmed there were no residents who currently received Jevity 1.5 calorie formula. When asked who had the responsibility for checking expiration dates in the medication rooms, the UM/LPN stated Central Supply, the Registered Dietitian (RD), and the unit managers. On 5/31/23 at 12:52 PM, the Director of Nursing	F 761	F761 Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) 483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 483.45(h) Storage of Drugs and Biologicals 483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. 483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. 1. Jevity Supplement that was expired was removed and properly discarded on	

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F 761	Continued From page 29 (DON), in the presence of the Licensed Nursing Home Administrator (LNHA), Regional Director of Clinical Services, Regional Director of Operations, and survey team, stated that Central Supply as well as the unit managers had the responsibility of checking expiration dates in the medication rooms. The DON acknowledged that the Jevity 1.5 calorie nutritional formula should have been pulled from the medication room within thirty days of the expiration date, and not available in the medication room for resident use. A review of facility's undated "Storage of Medications" policy included... 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner; 4. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed... A review of the facility's "Unit Manager Duties and Responsibilities" included... participate in the development, maintenance, implementation and updating of the written policies and procedures for the administration, storage, and control of medications and supplies.... 2. On 5/26/23 at 10:35 AM, the surveyor in the presence of the Director of Nursing (DON) reviewed eight DEA 222 forms provided which revealed the following: Order form number 221774084 dated 2/15/23, Part 5: to be filled in by Purchaser was not completed.	F 761	May 31, 2023. DEA 222 Form section 5 was not completed by purchaser. Inventory sheets for order form number 221774084 dated 2/15/23 and 221774078 dated 3/15/23 were obtained to verify receipt of narcotics issued on these dates. 2. All residents have the potential to be affected by this deficient practice. 3. DON/Designee will conduct an audit of all medication rooms and supply storage areas to identify supplement expiration dates on May 31, 2023. DON/Designee completed education on completion of section 5 on the copy of DEA 222 form, received by pharmacy, with Unit managers, Nursing supervisors, ADON and License Nursing Staff. 4. DON/Designee will audit medication rooms and supply storage areas weekly x 4, bi-weekly x 2, and monthly x 1 to ensure ongoing and sustained compliance with this deficient practice. DON will audit DEA 222 Forms section 5 for completion. DON will audit weekly x 4, monthly x3 to ensure forms are in compliance with this deficient practice. Findings will be reported monthly to the QAPI committee meeting until substantial compliance has been met. The QAPI committee consists of the DON, Administrator, and Medical Director. 5. June 12, 2023	

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F 761	Continued From page 30 Order form number 221774078 dated 3/15/23, Part 5: to be filled in by Purchaser was not completed. A review of the instructions for submission of the DEA 222 form located on the reverse side of the form included Part 5. Controlled Substance Receipt 1. The purchaser fills out this section on its copy of the original form. 2. Enter the number of packages received and the date received for each line item. At this time, the DON confirmed the two forms should have been completed for Part 5 as instructed. On 6/1/23 at 9:56 AM, the DON in the presence of the LNHA, Regional Director of Clinical Services, and survey team stated she completed the DEA 222 forms for the ordering of the narcotics for the backup medication system, but since the deliveries arrived to the facility at different hours, nursing supervisors received the medications. The DON acknowledged the receiving nurse should have completed Part 5 on the DEA 222 form at the time of receiving the order. NJAC 8:39(g); 29.7(c)	F 761		

New Jersey Department of Health

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	03015	A. BUILDING: ____ B. WING ____	C 06/01/2023

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 12 out of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	S560- 8:39-5.1 (a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. 1.No residents were affected by not meeting the State of New Jersey minimum staffing requirements. 2.All residents could have the potential to be affected by this area of concern. 3.Recruitment efforts continue to include: A.Daily Staffing meetings B.Care Champion mentor program to support and retain staff C.Culture Committee to promote and improve staff morale D.Recruitment Bonuses, Sign on Bonuses	6/12/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 06/16/23

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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. During entrance conference on 5/16/23 at 9:51 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON) stated that the facility's staffing was average. The facility had a call system to call nurse managers to come in as needed, as well as utilized Agency staff. At this time, the surveyor requested the facility to complete the "Nurse Staffing Report" for the past two weeks. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 4/30/23 to 5/6/23 and 5/7/23 to 5/13/23, which revealed the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 4/30/23 had 19 CNAs for 200 residents on the day shift, required 25 CNAs. 5/1/23 had 21 CNAs for 199 residents on the day shift, required 25 CNAs. 5/2/23 had 21 CNAs for 197 residents on the day	S 560	and Vacant Shift Bonuses offered E.Utilizing multiple outside staffing agencies to fulfill staffing needs F.Ongoing job fairs onsite G.On-demand orientation classes H.Prize raffles for staff picking up extra shifts I.Daily interviews being conducted with any walk ins 4.The Director of Nursing/Designee will monitor staffing daily x5, weekly x4, and monthly x3 to maintain ongoing staffing compliance. The Director of Nursing will report the results to the Quality Initiative Committee. The Quality Initiative committee consists of the Administrator, Director of Nursing, and the Medical Director. 5. Date when corrective action will be completed: June 12,2023	

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S 560	Continued From page 2	S 560		

shift, required 25 CNAs.
5/3/23 had 22 CNAs for 197 residents on the day shift, required 25 CNAs.
5/5/23 had 23 CNAs for 195 residents on the day shift, required 24 CNAs.
5/6/23 had 23 CNAs for 189 residents on the day shift, required 24 CNAs.
5/7/23 had 20 CNAs for 189 residents on the day shift, required 24 CNAs.
5/8/23 had 21 CNAs for 188 residents on the day shift, required 24 CNAs.
5/9/23 had 21 CNAs for 188 residents on the day shift, required 23 CNAs.
5/10/23 had 21 CNAs for 188 residents on the day shift, required 23 CNAs.
5/11/23 had 22 CNAs for 188 residents on the day shift, required 23 CNAs.
5/13/23 had 19 CNAs for 194 residents on the day shift, required 24 CNAs.

On 5/31/23 at 11:54 AM, the surveyor interviewed the Staffing Coordinator who stated one of her job responsibilities was to schedule all nursing staff which included nurses and CNAs. The Staffing Coordinator continued that staffing was completed based on the census with one assigned CNA to every eight residents for the day shift; one CNA for every ten residents for the evening shift; and one CNA for every fourteen residents for the night shift. The facility offered bonuses, sent messages to staff, asked staff to work another shift, and utilized Agency staff to cover callouts. The Staffing Coordinator stated staffing was challenging at times, but was overall pretty good.

NJAC 8:39-5.1(a)

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S1405	Continued From page 3	S1405		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure newly hired employees received a health physical examination by a physician or advanced practice nurse within two weeks prior to the first day of employment or upon employment. This deficient practice was identified for 5 of 5 newly hired employee files reviewed (Employee #1, #2, #3, #4, and #5), and was evidenced by the following: On 5/25/23 at 1:00 PM, the surveyor requested	S1405	S1405 –8:39-19.5 (a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced	6/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03015	A. BUILDING: ____ B. WING ____	C 06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCAR	**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) COMPLETE DATE
S1405	Continued From page 4 from the Licensed Nursing Home Administrator (LNHA) to provide five randomly selected newly hired employees' files including their health files for review. On 5/26/23 at 10:00 AM, the surveyor received the employee health files and was informed two of the five employees never started working at the facility, so the files were incomplete. The surveyor reviewed the three health files for employees who still worked at the facility which revealed the following: Employee #1, a Licensed Practical Nurse (LPN), was hired on [NJ Exec Order 26] The employee health file did not include a physical examination. Employee #2, a LPN, was hired on [NJ Exec Order 26]. The employee health file did not include a physical examination. Employee #3, a LPN, was hired on [NJ Exec Order 26] The employee health file did not include a physical examination. On 5/26/23 at 10:16 AM, the surveyor interviewed Human Resources (HR) who stated her job responsibility for new hires was to ensure they had all of their required vaccinations, schedule a two-step tuberculosis test, and completed health physical examinations. HR stated Agency staff usually brought their health physical examination on their first shift; and facility staff had in the past been seen by physicians at the facility including the Medical Director as well as the facility encouraged them to obtain a health physical examination prior to starting. HR continued the facility asked staff to obtain a health physical examination as soon as possible if the Medical Director was unavailable, but staff started working in the facility prior to having a health physical examination. HR stated when she received the	S1405	practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. 1. Human Resources Manager was reeducated on requirements for all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. 2.Due to the nature of the deficiency, all residents have the potential to be affected by this practice. 3. Human Resource Manager/Designee will ensure completeness of physical examinations during classroom orientation prior to any staff member being released to complete on the floor training. 4. The NHA/Designee will review all new hire files to ensure the completeness of employee physicals. Findings will be reported monthly to the QAPI meeting until substantial compliance has been met. 5. Date when corrective action will be completed: June 12, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03015	A. BUILDING: ______ B. WING ______	C 06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCAR	**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) COMPLETE DATE
S1405	Continued From page 5	S1405		

staff's health physical examination, she placed the examination in the employee's file. HR confirmed Employee #1, Employee #2, and Employee #3 did not have a health physical examination. At this time, the surveyor requested two additional employee files and the facility's policy for new hires.

On 5/26/23 at 10:48 AM, the surveyor interviewed the LNHA, Director of Nursing (DON), and the Infection Preventionist/LPN (IP/LPN) about the employee health process for new hires. The IP/LPN stated newly hired employees were given one of a two step tuberculosis test during orientation, and employee health physical examinations were the responsibility of HR and should be completed upon hire. At this time, the surveyor informed the LNHA, DON, and IP/LPN that the three employee files reviewed had not included health physical examinations. The LNHA confirmed the health examination physicals should have been completed upon hire.

On 5/26/23 at 11:07 AM, the LNHA provided the surveyor with the two additional employee files requested. The LNHA acknowledged at this time, these employees did not have health physical examinations either, and should have been completed upon hire.

The surveyor reviewed the two additional employee files which revealed the following:

Employee #4, a Certified Nursing Aide (CNA), was hired on [NJ Exec Order 26]. The employee health file did not include a physical examination.
Employee #5, a Registered Nurse (RN), was hired on [NJ Exec Order 26]. The employee health file did not include a physical examination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03015	A. BUILDING: ______ B. WING ______	C **06/01/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BROOK REHABILITATION AND HEALTHCAR	**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) COMPLETE DATE
S1405	Continued From page 6 On 6/1/23 at 9:56 AM, the LNHA in the presence of the DON, Regional Director of Clinical Services, and survey team acknowledged employee health physical examinations should be completed at orientation, or on orientation have an RN assessment with a health physical examination completed by a physician or advanced practice nurse within thirty days of hire. A review of the facility's undated "Medical Examinations (Physicals)" policy included...each potential employee, after receiving a conditional offer of employment, and each current employee whose job position necessitates such must undergo physical examination... NJAC 8:39-19.5(a)	S1405		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315524	A. Building B. Wing	7/17/2023

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 F0697 Reg. # 483.25(k) LSC	Correction Completed 06/12/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
6/1/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315524	A. Building B. Wing	7/17/2023

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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 06/12/2023	ID Prefix F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 06/12/2023	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 06/12/2023
ID Prefix F0697 Reg. # 483.25(k) LSC	Correction Completed 06/12/2023	ID Prefix F0759 Reg. # 483.45(f)(1) LSC	Correction Completed 06/12/2023	ID Prefix F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 06/12/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
6/1/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
03015 Y1	A. Building B. Wing Y2	7/17/2023 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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 06/12/2023	ID Prefix S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 06/12/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
6/1/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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 ___	**06/01/2023**

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
K 000	INITIAL COMMENTS The nursing home building construction was stated to be around 1990s with no current major renovations or noted additions. It is a two story building Type II (000) construction and is fully sprinklered. The building utilizes 2-interior natural gas generators 30 and 85 KW and does approximately 60% of the building. The 2-elevators have fire sprinkler protection at the top and bottom of each shaft as per the Maintenance Director. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility has 220 certified beds. At the time of the survey the census was 196. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used,	K 222		6/12/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 06/16/2023

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.

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 ______	**06/01/2023**

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
K 222	Continued From page 1 only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4	K 222		

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 ______	06/01/2023

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
K 222	Continued From page 2 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of Maintenance Director and Plant Operations Director on 5/17/23, it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6 for 2 of 2 sets of exterior exit/egress doors observed. This deficient practice was identified for 2 of 2 sets of doors and was evidenced as follows: On 5/17/23 at 11:08 AM, the surveyor, Maintenance Director (MD), and Regional Plant Operations Director (RPOD) observed two sets of glass sliding doors located at the front entrance of the facility; the interior and exit set of sliding doors had a lockset that engaged a hook-type deadbolt. The device on the door could restrict emergency use of the exit. The current evacuation plan indicated that the front doors were designated an exit/egress route. The two-sets of sliding door had signs indicating push to open in an emergency, but with the thumb-latch locks engaged this procedure would not open the doors	K 222	K222 Egress Doors CFR(s): NFPA 101 Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING. Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised	

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	06/01/2023

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

K 222

Continued From page 3

as stated on the signs.

At the time of the observation, the surveyor interviewed the MD and RPOD who stated that the lockset (hook type deadbolt) could restrict use of the exit from the egress-side in the event of an emergency.

The Licensed Nursing Home Administrator was notified of the findings at the Life Safety Code Exit Conference on 5/18/23.

NJAC 8:39-31.2(e)
NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6.
NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C

K 222

automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4
DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4
ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4
ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4

1. Lockset that engaged a hook-type deadbolt has been removed and replaced with a non-locking mechanism that will not

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	**06/01/2023**

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
K 222	Continued From page 4	K 222	restrict the emergency use of the exit. 2. All residents, staff, and visitors have the potential to be affected by this practice. 3.Audit completed on all emergency exit doors to ensure that no other emergency door in the facility is equipped with a lockset that engages a hook-type deadbolt. Any and all identified, hook-type, deadbolt lockset have been removed and replaced with a non-locking mechanism to not restrict the emergency use of the exit. Maintenance Director or Designee to conduct audits weekly x4, bi-weekly x2, for three months and then monthly. 4. Audit findings will be reviewed monthly by the Interdisciplinary Team at the QAPI committee meeting until substantial compliance has been met. 5. Date when corrective action will be completed: June 12, 2023	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 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.	K 321		7/15/23

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 ______	06/01/2023

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
K 321	Continued From page 5 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, interview, and document review on 5/18/23, in the presence of the Maintenance Director, Regional Plant Operations Director, and Vice President of Operations, it was determined that the facility failed to provide a fire barrier with two-hour fire resistance rating in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1 and 8.7.1. The deficient practice was evidenced for 1 of 5 hazardous areas observed. On 5/18/23 at 11:10 AM, the surveyor observed in the boiler room that an approximately eight feet by eight feet (8' x 4') section of wallboard was missing and falling down. The missing section of wallboard exposed falling insulation and unprotected wood. The area was now not fully protected in fire-rated material. The findings were verified by the Maintenance Director, Regional Plant Operations Manager, and Vice President of Operations at the time of the observations.	K 321	K321 Hazardous Areas – Enclosure CFR(s): NFPA 101 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.	

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	06/01/2023

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
K 321	Continued From page 6 The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 5/18/23. NJAC 8:39-31.2(e)	K 321	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) 1. The approximate eight feet by eight feet (8' x 4') section of wallboard that was missing and falling down and the missing section of wallboard exposed falling insulation and unprotected wood have been repaired. 2. All residents, staff, and visitors have the potential to be affected by this practice. 3. Maintenance Director conducted walk through audit to ensure that no wallboards, falling insulation, unprotected wood are exposed. Any and all wallboards, falling insulation, unprotected and exposed wood has been removed and repaired accordingly. Maintenance Director or Designee to conduct audits weekly x4, bi-weekly x2, and then monthly. 4. Audit findings will be reviewed monthly by the Interdisciplinary Team at the QAPI committee meeting until substantial compliance has been met. 5. Date when corrective action will be completed: July 15, 2023	
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to	K 341		7/15/23

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 ___	06/01/2023

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
K 341	Continued From page 7 provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/17/23, in the presence of the Maintenance Director, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 1 enclosed courtyard in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: On 5/17/23 at 11:20 AM, the surveyor and Maintenance Director (MD) observed in the main enclosed courtyard, no evidence of a fire alarm notification (horn/strobe) device. An interview was conducted during the observation and the surveyor asked the MD, if there was a horn/strobe, tied into the fire alarm system within the main courtyard. The MD confirmed that currently there are no horn/strobe devices tied into the fire alarm system in the	K 341	K341 Fire Alarm System – Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 1. Horn/strobe device tied into the fire alarm system in the enclosed courtyard has been installed. 2. All residents, staff, and visitors have the potential to be affected by this practice. 3. Maintenance Director conducted facility	

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 ______	06/01/2023

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

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K 341	Continued From page 8 enclosed courtyard observed. The Licensed Nursing Home Administrator was notified of the findings at the Life Safety Code exit conference on 5/18/23. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341	audit to ensure effective warning of fire is provided at all parts of the building. No other areas warranting additional components identified. Maintenance Director or Designee to conduct audits weekly x4, bi-weekly x2, and then monthly. 4. Findings will be reported monthly to the QAPI committee meeting until substantial compliance has been met. 5. Date when corrective action will be completed: July 15, 2023	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/18/23, in the presence of the Maintenance Director, Regional Plant Operations Director, and Vice President of Operations, it was determined that the facility failed to provide smoke barrier wall doors that completely closed to resist the	K 374	K374 Subdivision of Building Spaces - Smoke Barrier CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch-thick solid bonded wood-core doors or of	7/15/23

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 ______	**06/01/2023**

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
K 374	Continued From page 9 passage of smoke, flame, or gases during a fire in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.7, 19.3.7.1, 19.3.7.8, 8.5, 8.5.2, 8.5.4, 8.5.4.1. This deficient practice was identified for 2 of 6 sets of double smoke door sets observed and tested for closure, and was evidenced by the following: 1. On 5/18/23 at 10:47 AM, the surveyor observed that the set of smoke doors by the employee lounge, when released from the auto-magnetic hold-open device fully closed, were observed to be compromised at the bottom twelve inches (12") meeting point, due to the set of doors not being smoke resistant. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire compromising the integrity of the smoke zone. 2. On 5/18/23 at 11:10 AM, the surveyor observed that the set of smoke doors by the East-wing spa, when closed were not fully smoke resistant as the gap between the doors was approximately 1/4" in size. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire compromising the integrity of the smoke zone. The Maintenance Director, Regional Plant Operations Director, and Vice President of Operations all confirmed the findings during the building tour observations. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 5/18/23.	K 374	construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 1. The two sets of smoke doors that were deemed to not be smoke resistant due to when closed were not fully smoke resistant as the gap between the doors was approximately 1/4" in size, have been replaced. 2. All residents, staff, and visitors have the potential to be affected by this practice. 3. Maintenance Director conducted building walk through audit to ensure that smoke barrier wall doors completely close to resist the passage of smoke, flame, or gases. Any and all smoke barrier walls that were found to not completely close have been repaired. Maintenance Director or Designee to conduct audits weekly x4, bi-weekly x2, and then monthly. 4. Monitor Corrective Actions: Findings will be reported monthly to the QAPI committee meeting until substantial compliance has been met. 5. Date when corrective action will be completed: July 15, 2023	

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 ______	06/01/2023

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

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K 374	Continued From page 10 NJAC 8:39-31.2(e)	K 374		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/18/23, in the presence of the Maintenance Director, Regional Plant Operations Director, and Vice President of Operations, it was determined that the facility failed to ensure resident bathroom ventilation systems were adequately maintained and operating in optimal condition, in accordance with the National Fire Protection Association (NFPA) 90 A. This deficient practice was identified for 32 of 100 resident room bathrooms vents observed and was evidenced by the following: While touring the building on 5/18/23 from 9:30 AM to approximately 1:00 PM, the surveyor with the Maintenance Director (MD), Regional Plant Operations Director (RPOD), and Vice President of Operations (VPO) observed that the ventilation systems did not function when the MD applied a piece of single-ply toilet tissue paper across the upper ceiling grills to confirm ventilation. When	K 521	K521 HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 1. Ventilation system was assessed by Maintenance Director and found to have a faulty motor that resulted in a malfunction to the ventilation system. The motor was repaired and ventilation system is now functioning properly. 2. All residents, staff, and visitors on the East Unit have the potential to be affected by this practice. 3. Maintenance Director conducted facility audit to ensure HVAC Heating, ventilation and air conditioning shall be fully operational and in compliance with manufacturers' specifications. Facility deemed all ventilations systems to be	6/12/23

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 ______	06/01/2023

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
K 521	Continued From page 11 tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. The resident room bathrooms were identified on the East-wing nursing units as: #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, and #83. An interview was conducted with the MD during the observations, and he confirmed the findings. The MD stated the roof unit may have a bad motor and/or a broken fan belt. He stated currently the facility ventilation system in resident rooms was not functioning and the facility did not have a ventilation inspection log or operating check list to provide. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 5/18/23. NFPA 90 A Standard for the installation of ventilating systems NFPA 101-2012 -19.5.2.1 section 9.2.1 and 9.2.2 NJAC 8:39-31.2(e)	K 521	working properly. Maintenance Director or Designee to conduct audits weekly x4, bi-weekly x2, and then monthly. 4. Findings will be reported monthly to the QAPI committee meeting until substantial compliance has been met. 5. Date when corrective action will be completed: June 12, 2023	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	K 911		6/12/23

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 ______	**06/01/2023**

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
K 911	Continued From page 12 Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation on 5/18/23, in the presence of the Maintenance Director, Regional Plant Operations Director, and Vice President of Operations, the facility failed to demonstrate reliability regarding fuel supply in accordance with NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4. for 2 of 2 generators. This deficient practice was evidenced by the following: On 2/23/23 at 12:05 PM, the surveyor and Maintenance Director (MD) reviewed all the facility's generator documentation. The facility currently had two interior 85 and 30 KW (kilowatt) natural gas generators. The MD could not produce a documented reliability letter from the natural gas provider. Reliability letters from the natural gas vendor regarding fuel supply must contain all of the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption. 5. The signature of technical personnel from the natural gas vendor. The MD confirmed there was no reliability letter	K 911	K911 Electrical Systems – Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) 1. Facility attained reliability letter from natural gas provider, Public Service Electric & Gas Company, on 05/18/23. 2.All residents, staff, and visitors have the potential to be affected by this practice. 3. Maintenance Director will be educated on K911 to ensure compliance is maintained. 4. Administrator/Designee will ensure that reliability letter is updated as needed and yearly at a minimum. Findings will be reported to the QAPI committee meeting until compliance has been met. 5. Date when corrective action will be completed: June 12, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
K 911	Continued From page 13 available from the natural gas provider for the two natural gas generators for the facility to present to the surveyor. No additional information was received. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 5/18/23. NJAC 8:39-31.2(e) NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4.	K 911		

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 01 - LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER B. Wing (Y2)	7/17/2023 (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 Reg. # NFPA 101 LSC K0222	Correction Completed 06/12/2023	ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 07/15/2023	ID Prefix Reg. # NFPA 101 LSC K0341	Correction Completed 07/15/2023
ID Prefix Reg. # NFPA 101 LSC K0374	Correction Completed 07/15/2023	ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 06/12/2023	ID Prefix Reg. # NFPA 101 LSC K0911	Correction Completed 06/12/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
6/1/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO