STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315008	A. BUILDING ______ B. WING ______	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTHCARE AND REHABILITATION CENTER	**18 W LAUREL ROAD STRATFORD, NJ 08084**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ#169185 Census: 97 Sample Size: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
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 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	F 761		12/20/23

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

Electronically Signed | | 12/21/2023

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.

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

PRINTED: 03/20/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315008	A. BUILDING ______ B. WING ______	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTHCARE AND REHABILITATION CENTER	**18 W LAUREL ROAD** **STRATFORD, NJ 08084**

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F 761	Continued From page 1 systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Complaint #: NJ#169185 Based on interview, and record review on 11/21/23 and 11/22/23, it was determined that the facility failed to ensure that discontinued medications for Resident #1 were removed from the active inventory. The failure resulted in the Licensed Practical Nurse (LPN) administering Resident #1's medication to Resident #2. This deficient practice was identified for Resident #1 and Resident #2, 2 of 4 residents reviewed and was evidenced by the following: According to the "Admission Record," Resident #1 was admitted to the facility on [redacted] with medical diagnoses that included but were not limited to: [redacted] Review of Resident #1's "Order Summary Report" (OSR), for active orders as of [redacted] revealed a "physician's order" (PO), dated [redacted] for [redacted] Review of Resident #1's [redacted] "Medication Administration Record" (MAR) revealed the aforementioned [redacted] PO for	F 761	F761 Label/store drugs and biologicals - All discontinued or changed medication has been removed from the unit. The affected Resident Family and Doctor are aware and investigation including clinical evaluation completed. Licensed Staff educated on proper medication removal when discontinued or changed. - All residents with changed or discontinued medication can be affected by Laurel Manor failing to discard medication within the acceptable time frame. Should the medication be discontinued or changed, the nurse is instructed to remove it from circulation (out of the med cart, med room or refrigerator) once it has been discontinued. The medications must be removed within 24-48 hours of change of orders. -All nurses are in-serviced on what to do when a medication is discontinued or changed. The nurse assigned to the patient is responsible to remove discontinued or changed medication. Medications are Never to be borrowed. Nurse Managers or designee will conduct weekly audits x 4, then monthly x 2, then quarterly x 3 to ensure compliance. - Medications are Never to be borrowed.	

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	315008	A. BUILDING ______ B. WING ______	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTHCARE AND REHABILITATION CENTER	18 W LAUREL ROAD STRATFORD, NJ 08084

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F 761	Continued From page 2 [redacted] and to administer [redacted], one time a day, with the administration time of 9:00 AM. The MAR revealed that Resident #1 received the medication from [redacted] until [redacted] According to the "Admission Record," Resident #2 was admitted to the facility on [redacted] with medical diagnoses that included but were not limited to: [redacted] Review of Resident #2's OSR, for active orders as of [redacted], revealed a PO, dated [redacted] for [redacted] Review of Resident #2's [redacted] revealed the aforementioned [redacted] PO for [redacted] one time a day with the administration time of 9:00 AM. The MAR revealed that Resident #2 received the medication from [redacted] Review of the facility's 11/15/23 "Complaint Grievance Report", completed by the Social Worker (SW), indicated the facility "verified with the family that the correct medication was given with the wrong patient's name on it." Under the "Documentation of Investigation" section, completed by the LNHA, indicated "Correct medication, dose and time, however wrong patient name on the vial." Review of the 11/15/23 "Disciplinary Report Form," completed by the Assistant Director of	F 761	Nurse Managers or designee will conduct weekly audits x 4, then monthly x 2, then quarterly x 3 to ensure compliance. All audit results and any possible discrepancy will be presented to our monthly QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315008	A. BUILDING ______ B. WING ______	C **11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTHCARE AND REHABILITATION CENTER	**18 W LAUREL ROAD** **STRATFORD, NJ 08084**

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F 761	Continued From page 3	F 761		

Nursing (ADON), revealed the day shift agency LPN was identified and that the "employee did not verify and borrowed medication".

Review of the "Investigation of Incident/Accident Statement" revealed the LPN's statement that "I was assigned to Resident #2 on [redacted]. I provide [redacted] medication as I was ordered by the "medical doctor" (MD). I did not realize, by mistake, I took another resident's medication. Medication was the same strength as ordered by the physician but the incorrect name. Resident #2 was stable throughout the shift."

Review of a meeting summary completed on 11/15/23 at 3:30 PM by the Licensed Nursing Home Administrator (LNHA), indicated the LNHA, Unit Manager (UM) and SW met with Resident #2's [redacted] to discuss questions about Resident #2's care. The daughter mentioned in the meeting that she noticed the correct medication was given but it had someone else's name on the medication.

During an interview with the surveyor on 11/21/23 at 12:10 PM, the LNHA stated Resident #2's spouse and daughter reported to him on [redacted] they noticed the wrong name on Resident #2's [redacted]. The LNHA further stated he identified the LPN assigned to the resident and an investigation was initiated by the facility. The LNHA stated he obtained a verbal statement from the LPN, which indicated she substituted the medication for Resident #2.

During an interview with the surveyor on 11/21/23 at 1:58 PM, the Director of Nursing (DON) stated Resident #2 had medication available on the unit,

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F 761	Continued From page 4 so she was not sure why the LPN used Resident #1's medication. The DON also stated Resident #1 was on the [redacted] in [redacted] and that it had been discontinued on [redacted]. During an interview with the surveyor on 11/21/23 at 2:52 PM, the SW stated that on 11/15/23 she attended a meeting with the LNHA, ADON, UM and Resident #2's spouse and daughter. Resident #2's spouse brought a concern to the SW about Resident #2's [redacted] bag, which contained the same medication he was receiving, but had another resident's name on the bag. The SW stated the Unit Manager (UM) would address the issue and investigate further. During a follow-up interview with the surveyor on 11/22/23 at 11:58 AM, the DON stated Resident #1's [redacted] was discontinued on [redacted]. The DON added that once a medication is completed or ended, the nurses should gather all medications, place them in a secured stapled bag, and have the medication picked up the next day. The DON further stated, "After a resident is discontinued or finished with a medication, the medication should be discarded." Review of the facility's "Medication Storage" policy, with a reviewed date of 03/2023, revealed under the "Policy" section that it is the policy and procedure of this facility to store medications in a safe and proper manner, following all manufacturers recommendations. The policy further revealed under the "Procedure" section that "3. No discontinued, outdated, or deteriorated medications are available for use in this facility. All such medications are destroyed."	F 761		

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F 761	Continued From page 5 NJAC 8:39-29.4(g)	F 761		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060405	A. BUILDING: ______ B. WING ______	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTHCARE AND REHABIL	18 W LAUREL ROAD STRATFORD, NJ 08084

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S 000	Initial Comments CENSUS: 97 SAMPLE SIZE: 4 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 on 11/21/23 and 11/22/23, 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 21 out of 21 day shifts and 17 out of 21 evening shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	S560 1) The staffing coordinator was educated on the required minimum direct care staff-to- resident ratios as mandated by the state of New Jersey. The facility will continue to reach out to existing staff to see if they want to pick up overtime shifts and continue to try and staff accordingly 2) All residents have the ability to be	12/20/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/21/23

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 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 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. The surveyor requested staffing for the weeks of 10/29/23 to 11/04/23, 11/05/23 to 11/11/23 and 11/12/23 to 11/18/23. As per the "Nurse Staffing Report," completed by the facility for the weeks of 10/29/23 to 11/18/23, the facility was deficient in CNA staffing for residents on 21 of 21 day shifts and 17 of 21 evening shifts as follows: -10/29/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -10/30/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -10/30/23 had 8 CNAs for 21 total staff on the	S 560	affected by the facility failing to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. 3) The facility will continue to post job openings on job sites to promote CNA openings The facility is offering a sign on bonus The facility has contracted with agency to assist with our staffing needs The administrator/designee will review the daily staffing sheets weekly x 4 then monthly for 3 months and quarterly thereafter. 4) The Administrator/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine frequency of future audits.	

New Jersey Department of Health

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S 560	Continued From page 2 evening shift, required at least 10 CNAs. -10/31/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -10/31/23 had 9 CNAs to 22 total staff on the evening shift, required at least 11 CNAs. -11/01/23 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs. -11/01/23 had 9 CNAs to 22 total staff on the evening shift, required at least 11 CNAs. -11/02/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -11/02/23 had 9 CNAs to 23 total staff on the evening shift, required at least 11 CNAs. -11/03/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -11/03/23 had 9 CNAs to 23 total staff on the evening shift, required at least 11 CNAs. -11/04/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -11/05/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -11/06/23 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. -11/06/23 had 8 CNAs to 21 total staff on the evening shift, required at least 10 CNAs. -11/07/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -11/07/23 had 9 CNAs to 24 total staff on the evening shift, required at least 12 CNAs. -11/08/23 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. -11/08/23 had 9 CNAs to 21 total staff on the evening shift, required at least 10 CNAs. -11/09/23 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -11/09/23 had 9 CNAs to 23 total staff on the evening shift, required at least 11 CNAs. -11/10/23 had 10 CNAs for 97 residents on	S 560		

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	060405	A. BUILDING: ______ B. WING ______	C 11/21/2023

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S 560	Continued From page 3 the day shift, required at least 12 CNAs. -11/10/23 had 7 CNAs to 21 total staff on the evening shift, required at least 10 CNAs. -11/11/23 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs. -11/11/23 has 6 CNAs to 15 total staff on the evening shift, required at least 7 CNAs. -11/12/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -11/13/23 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -11/13/23 had 8 CNAs to 20 total staff on the evening shift, required at least 10 CNAs. -11/14/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -11/14/23 had 9 CNAs to 23 total staff on the evening shift, required at least 11 CNAs. -11/15/23 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs. -11/15/23 had 9 CNAs to 22 total staff on the evening shift, required at least 11 CNAs. -11/16/23 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. -11/16/23 had 9 CNAs to 23 total staff on the evening shift, required at least 11 CNAs. -11/17/23 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -11/17/23 had 7 CNAs to 21 total staff on the evening shift, required at least 10 CNAs. -11/18/23 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs. -11/18/23 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060405	A. Building B. Wing	12/29/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTHCARE AND REHABILITATION CENTER	18 W LAUREL ROAD STRATFORD, NJ 08084

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 12/28/2023	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	
11/21/2023	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315008 Y1	A. Building B. Wing Y2	12/29/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTHCARE AND REHABILITATION CENTER	18 W LAUREL ROAD STRATFORD, NJ 08084

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 F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 12/28/2023	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 11/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			