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 _____	**05/21/2024**

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 TYPE OF SURVEY: Renovation Project: This inspection of Phase 1 included the following areas: - Long Term Care Unit #1, New Large Dining room and exit access corridor. Census: 210 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/21/2024, and Laurel Brook Rehabilitation and Healthcare Center was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies for the newly renovated Rehabilitation Gym and Dining Room. Laurel Brook Rehabilitation and Healthcare Center construction was stated to be around 1990's. It is a two story building Type II (000) construction and is fully sprinkler. The building utilizes 2-interior natural gas generators 30 and 85 KW and does approximately 60% of the building. 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 above New Large Dining room may not be occupied until formal notification by the Certificate of Need and Licensing Division has been	K 000		

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

Electronically Signed | 06/12/2024

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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	315524	A. BUILDING **01** B. WING _____	**05/21/2024**

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	Continued From page 1 received.	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 05/21/2024, it was determined that the facility failed to provide one (1) illuminated exit sign to clearly identify the exit access path to reach an exit discharge door per NFPA 101, 2012 edition, Sections 7.10.1.5.1 and 7.10.5.2.1. The deficient practice had the potential to affect all 210 residents and was evidenced by the following: On 05/21/2024, the surveyor reviewed the facility provided lay-out that identified the Long Term Care Unit #1, New Dining room as being renovated. The surveyor observed that as you leave the new dining room and look to the left in the exit access corridor, there was no illuminated exit sign that would lead you to a second exit discharge door. The[US FOIA (b) (6)]) and [US FOIA (b) (6)]	K 293	In accordance with NFPA 101, 2012 edition, Sections 7.10.1.5.1 and 7.10.5.2.1, an exit sign will be installed in the corridor outside the new dining room in long term care unit #1. The exit sign will clearly identify the exit access path from the dining room to reach a second exit discharge door. The exit sign will be installed no later than 6/20/24. All residents have the potential to be affected by this deficient practice. An audit of the facility was conducted to ensure illuminated exit signs that clearly identify the exit access path to reach an exit discharge door per NFPA 101, 2012 edition, Sections 7.10.1.5.1 and 7.10.5.2.1. Any new construction or renovation projects at the facility will be properly inspected by a contracted engineer prior to utilizing such areas to ensure	6/20/24

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 _____	**05/21/2024**

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 293	Continued From page 2 US FOIA (b) (6) confirmed the finding at the time of observations. The US FOIA (b)(6) US FOIA and US FOIA were informed of the deficiency during the survey exit on 05/21/2024 at approximately 10:10 AM. NJAC 8:39 -31.1 and 8:39 -31.1 (c)	K 293	illuminated exit signs that clearly identify the exit access path to reach an exit discharge door per NFPA 101, 2012 edition, Sections 7.10.1.5.1 and 7.10.5.2.1. All outcomes from the audits and inspections will be reviewed by the Interdisciplinary Team at the monthly QAPI Meeting for compliance.	
K 347 SS=D	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 05/21/2024, in the presence of the US FOIA (b) (6) and US FOIA (b) (6)), it was determined that the facility failed to ensure that areas open to the corridor were provided with smoke detection in accordance with NFPA 101, 2012 Edition, Section 19.3.6.1 and 19.3.4.5.2. The deficient practice could affect 210 residents and was observed in 1 of 1 unoccupied renovated Long Term Care Unit #1 new dining room open area by the following: At 9:48 AM, in the presence of the US FOIA and US FOIA the surveyor inspected the newly renovated dining room and observed no smoke detectors.	K 347	In accordance with NFPA 101, 2012 edition, Sections 19.3.6.1 and 19.3.4.5.2, (6) analog photoelectric smoke detectors will be installed in the dining room by the alarm vendor no later than 6/20/24. As directed by the engineer of record, the smoke detectors will be installed in two rows of three Smoke detectors. Detectors will be no more than 15 feet from a wall and no more than 30 ft apart from each other. All residents have the potential to be affected by this deficient practice. An audit of all facility areas open to corridor was conducted for proper smoke detection in accordance NFPA 101, 2012 Edition, Section 19.3.6.1 and 19.3.4.5.2.	6/20/24

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	315524	A. BUILDING **01** B. WING _____	**05/21/2024**

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 347	Continued From page 3 A review of the DCA approved project #5135-22 partial release dated 11/02/2022 identified no smoke detectors in the New Dining room. The US FOIA and US FOIA both confirmed the finding at the time of the observation. The US FOIA (b) (6), US FOIA and US FOIA were informed of the deficiency during the survey exit on 05/21/2024 at approximately 10:10 AM. NJAC 8:39-31.1(c), 31.2(e)	K 347	Any new construction or renovation projects at the facility will be properly inspected by a contracted engineer prior to utilizing such areas to ensure proper smoke detection in accordance NFPA 101, 2012 Edition, Section 19.3.6.1 and 19.3.4.5.2. All outcomes from the audits and inspections will be reviewed by the Interdisciplinary Team at the monthly QAPI Meeting for compliance.	

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 01 - LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER B. Wing	7/5/2024

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 K0293	Correction Completed 06/20/2024	ID Prefix Reg. # NFPA 101 LSC K0347	Correction Completed 06/20/2024	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
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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 5/21/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			