

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

PRINTED: 02/11/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315524</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/16/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3718 CHURCH ROAD</b> <b>MOUNT LAUREL, NJ 08054</b>
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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
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F 000	INITIAL COMMENTS  Complaint #: NJ179543  Survey Date: 1/16/2025  Census: 185  Sample: 3  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 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		2/4/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>02/03/2025</b>
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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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NAME OF PROVIDER OR SUPPLIER  <b>LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3718 CHURCH ROAD</b> <b>MOUNT LAUREL, NJ 08054</b>		
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F 880	<p>Continued From page 1</p> <p>and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p>	F 880			

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F 880	<p>Continued From page 2</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Complaint #: NJ179543</p> <p>Based on observation, interview, and review of pertinent facility documents on 1/16/2025, it was determined that the facility failed to follow appropriate hand hygiene during an observation of a resident's <b>NJ Exec Order</b> treatment for 1 of 3 residents ( Resident #1). This deficient practice has the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice and facility policy as evidenced by the following:</p> <p>According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient ... Before moving from work on a soiled body site to a clean body site on the same patient ... After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces</p>	F 880	<ol style="list-style-type: none"> <li>1. Resident #1 still resides at the facility. <b>NJ Exec Order 26.4b1</b> as resulted by the deficient practice.</li> <li>2. All residents have the potential to be affected by this deficient practice.</li> <li>3. The Infection Preventionist re-educated all licensed nurses on the facility infection prevention policy to include but not limited to performing hand hygiene before preparing and administering wound treatments/dressing changes. Resident #1 was reviewed by the licensed nurse with <b>NJ Exec Order 26.4b1</b> noted. The Infection Preventionist re-educated LPN #1 on the facility infection prevention policy to include but not limited to performing hand hygiene before preparing and <b>NJ Exec Order 26.4b1</b> of any <b>NJ Exec Order</b> care treatment. An audit was completed during wound treatments with dressing changes to determine if nurses were following proper infection control and hand hygiene. No further variances were noted.</li> <li>4. The Infection Preventionist /designee</li> </ol>		

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F 880	<p>Continued From page 3</p> <p>Immediately after glove removal.</p> <p>On 1/16/2025 at 9:43 A.M., during a unit tour with the <b>US FOIA (B) (6)</b> the surveyor observed Resident #1 in <b>NJ ex order 26.4b1</b></p> <p>The surveyor reviewed the medical record for Resident #1.</p> <p>A review of the Resident's Face Sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses which <b>NJ ex order 26.4b1</b></p> <p>A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated <b>NJ ex order 26.4b1</b>, revealed a score of <b>NJ ex</b> out of 15, which indicated the resident <b>NJ ex order 26.4b1</b>. The MDS also revealed the resident <b>NJ ex order 26.4b1</b></p> <p>A review of the Physician's Orders dated <b>NJ ex order 26.4b1</b> <b>NJ ex order 26.4b1</b></p>	F 880	<p>will audit during wound treatments/dressing changes, to determine if nurses were following proper infection control and hand hygiene protocols. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Infection Preventionist to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained.</p>		

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F 880	<p>Continued From page 4</p> <p>On 1/16/2025 at 11:12 A.M., the surveyor observed the <b>US FOIA (B) (6)</b> in the presence of the <b>US FOIA (B) (6)</b> perform a <b>NJ Exec Order</b> care treatment on Resident #1 and observed the following:</p> <p>The <b>US FOIA (B) (6)</b> entered the resident's room used an alcohol-based hand rub (ABHR), placed gloves on and sanitized the resident's bedside table with Super Sani-cloth wipes. After allowing the bedside table to air dry for approximately 60 seconds, he placed the <b>NJ Exec Order</b> treatment supplies on the resident's bedside table.</p> <p>The <b>US FOIA</b> than placed clean gloves on without washing her hands with soap and water, she dated, and initial the <b>NJ Exec Order 26.4b1</b>. Resident #1 <b>NJ ex order 26.4b1</b>. The <b>US FOIA NJ ex order 26.4b1</b> without removing her contaminated gloves and washing her hands with soap and water, she <b>NJ ex order 26.4b1</b>. The <b>US FOIA (B) (6)</b> attempted to <b>NJ ex order 26.4b1</b> when the <b>US FOIA (B) (6)</b> said, "NJ ex order 26.4b1." The <b>US FOIA (B) (6)</b> than <b>NJ ex order 26.4b1</b> she applied a clean pair of gloves, and <b>NJ ex order 26.4b1</b></p> <p>At 11:26 A.M., the surveyor attempted to interview the <b>US FOIA</b> who at this time refused to be interviewed. In the presence of the <b>US FOIA</b>, the <b>US FOIA (B) (6)</b> confirmed the surveyor's observation that the <b>US FOIA</b> did not perform hand hygiene prior to and during Resident #1's <b>NJ ex order 26.4b1</b>.</p> <p>At 11:35 A.M., during an interview with the <b>US FOIA (B) (6)</b> in the presence of the <b>US FOIA (B) (6)</b></p>	F 880		

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F 880	<p>Continued From page 5</p> <p><b>US FOIA (B) (6)</b> he confirmed the <b>US FOIA</b> did not perform hand hygiene prior to and during Resident #1's <b>NJ Exec Order</b> care treatment. The <b>US FOIA (B) (6)</b> further stated, the <b>US FOIA</b> did not follow the facility's policy for <b>NJ Exec Order</b> care and infection control. During the same interview, the <b>US FOIA</b> stated the importance of performing hand hygiene during <b>NJ Exec Order</b> care is to prevent cross contamination which has a potential for infection.</p> <p>At 12:16 P.M., during an interview with the <b>US FOIA (B) (6)</b> she stated, her expectation would be for the <b>US FOIA</b> to perform hand hygiene before and during a <b>NJ Exec Order</b> care treatment, remove soiled gloves after removing a <b>NJ Exec Order 26.4b1</b> and apply clean gloves to provide <b>NJ Exec Order</b> care and to follow the facility's <b>NJ Exec Order</b> care policy. The <b>US F</b> stated, "if these steps are not followed, the <b>NJ Exec Order</b> could become infected, and the patient could become <b>NJ Exec Order 2</b></p> <p>A review of the facility's "Wound Care" policy dated revised October 2010, included the purpose of this procedure is to provide guidelines for the care of wounds to promote healing...steps in the procedure...2. wash and dry your hands thoroughly. 4. Put on exam gloves. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly.</p> <p>A review of the facility's "Handwashing/Hand Hygiene" policy dated August 2021, under "Policy Statement" reveals: this facility considers hand hygiene the primary means to prevent the spread of infections. Under "Policy Interpretation and Implementation" revealed: 6. Use an alcohol-based hand rub containing at least 60% alcohol; or, alternatively, soap (antimicrobial or</p>	F 880		

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F 880	Continued From page 6 non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; g. Before handling clean or soiled dressing, gauze pads, etc.; k. After handling used dressing, contaminated equipment, etc  NJAC 8:39-19.4(a)	F 880		

New Jersey Department of Health

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S 000	<p>Initial Comments</p> <p>THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG-TERM CARE FACILITIES.</p>	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

02/03/25

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315524 <span style="float: right;">Y1</span>	MULTIPLE CONSTRUCTION A. Building _____ B. Wing _____	DATE OF REVISIT 2/4/2025 <span style="float: right;">Y2</span>
NAME OF FACILITY LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 F0880	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	02/04/2025	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS) _____	DATE _____	SIGNATURE OF SURVEYOR _____	DATE _____
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS) _____	DATE _____	TITLE _____	DATE _____

FOLLOWUP TO SURVEY COMPLETED ON 1/16/2025
  CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
  YES  NO