	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 01	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315524	B. WING		04/28/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	04/20/2021
			37	18 CHURCH ROAD	
LAUREL E		ON AND HEALTHCARE CENTER	м	OUNT LAUREL, NJ 08054	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
E 000	Initial Comments		E 000		
K 000	Appendix Z-Emerge Provider and Suppli		K 000		
	LIFE SAFETY COL	DE 101:2012			
	two-story building th	o and Healthcare is a nat was built in 1980's. It is V (111) construction and is			
	the corridors, space resident rooms, The North 1 Emergency	smoke detection located in as open to the corridors and in are are two generators 1. Generator and Back Boiler th natural gas units.			
	regulatory flexibilitie Emergency for routi maintenance requin 2020. The flexibilitie following items: fire fire extinguisher mo operation monthly to testing of generator	1135 waivers allowing for es during the Public Health ne inspection, testing and ements beginning January 31, es did not extend to the pump weekly/monthly testing, nthly inspections, fire fighter esting for elevators, monthly s, and daily inspection of the areas of construction, repair,			

Electronically Signed

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.

05/11/2021

		MEDICAID SERVICES			DMB NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING (E CONSTRUCTION D1	(X3) DATE SURVEY COMPLETED	
		315524	B. WING		04/28/2021	
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUREL I	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
K 000	Continued From page alterations or additior		K 000			
	COVID-19 PHE as al All. The process revis	vas modified during this lowed by QSO Memo 20-31- sions excluded f the rooms and portions of				
	The facility has 220 c the survey the censu	ertified beds. At the time of s was 161.				
	The requirement at 4 NOT MET as evidence	2 CFR Subpart 483.90(a) is ed by:				
K 281 SS=D	Illumination of Means CFR(s): NFPA 101	of Egress	K 281		5/14/21	
	discharge, is arrange shall be either continu capable of automatic intervention. 18.2.8, 19.2.8	of egress, including exit d in accordance with 7.8 and				
	determined that the fa sources of illuminatio common way for eva	aintenance Director, it was acility failed to provide 2 n at exit discharges to the		Preparation and/or execution of this pla of correction does not constitute an admission or agreement by the Provide of the truth or the facts alleged, or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the	r	
	following:			provisions of Federal and State Laws th require it.	at	
	egress door identified	surveyor observed at the as # by resident room ontained one-bulb and the		1.Maintenance Director/ designee replaced the one-bulb fixtures identified	in	

Event ID: J96K21

Facility ID: NJ03015

If continuation sheet Page 2 of 12

-	ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVE 0. 0938-039
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION	(X3) DATE	
	315524	B. WING			04	28/2021
ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
			3718	3 CHURCH ROAD		
			МО	UNT LAUREL, NJ 08054		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG				(X5) COMPLETION DATE
		K 28	81			
overlapping light path fixtures, in the event a evacuation. 2. At 11:25 A.M., the egress door identified contained one-bulb a fixture was approxima surrounding was not the event a resident of An interview was con Director at the time of stated that he was un NJAC 8:39 - 31.2(e)	ern from neighboring a resident emergency surveyor observed at the d as # that the fixture nd the next rooftop light ately 50' away and the provided with enough light in emergency evacuation. ducted with the Maintenance f the observations and he naware of this requirement.			before 5/14 to a double-bulb fixtures, doubling the lumens output. 2.All other exit discharges were audite the Maintenance Director/ designee or before 5/14 to ensure proper illuminati Any notable areas were addressed accordingly. 3.On or before 5/14, the regional Direct of Plant Operations/Designee will cond in-service training to the maintenance staff on NFPA 101 proper illuminations means of egress. 4.Audit to be conducted bi-weekly by t maintenance director/designee on exit discharge illumination to ensure prope illumination. Audit will be conducted fo months or until QAPI committee deem appropriate. QAPI committee will meet	d by n or on. ctor duct at he r 3 s	
		K 29		montany.		5/14/21
accordance with 7.10 also served by the en 19.2.10.1 (Indicate N/A in one-s with less than 30 occ travel is obvious.) This REQUIREMENT by: Based on observatio in the presence of the	with continuous illumination nergency lighting system. story existing occupancies upants where the line of exit is not met as evidenced on and interview on 04/28/21, Maintenance Director, it			of correction does not constitute an		
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER BROOK REHABILITATIO SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page surrounding area was overlapping light patt fixtures, in the event is evacuation. 2. At 11:25 A.M., the egress door identified contained one-bulb a fixture was approxima surrounding was not the event a resident of An interview was com Director at the time o stated that he was ur NJAC 8:39 - 31.2(e) 19.2.9.1 (Emergency Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional si accordance with 7.10 also served by the er 19.2.10.1 (Indicate N/A in one-si with less than 30 occ travel is obvious.) This REQUIREMENT by: Based on observatio in the presence of the was determined that	S FOR MEDICARE & MEDICAID SERVICES DE DEFICIENCIES CORRECTION (x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315524 ROVIDER OR SUPPLIER BROOK REHABILITATION AND HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 surrounding area was not provided with enough overlapping light pattern from neighboring fixtures, in the event a resident emergency evacuation. 2. At 11:25 A.M., the surveyor observed at the egress door identified as # that the fixture contained one-bulb and the next rooftop light fixture was approximately 50' away and the surrounding was not provided with enough light in the event a resident emergency evacuation. An interview was conducted with the Maintenance Director at the time of the observations and he stated that he was unaware of this requirement. NJAC 8:39 - 31.2(e) 19.2.9.1 (Emergency Lighting) 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 interview on 04/28/21, in the presence of the Maintenance Director, it was determined that the facility failed to properly	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTI A. BUILDIN 315524 ROVIDER OR SUPPLIER 315524 B. WING_ ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Continued From page 2 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) K 2 Continued From page 2 Surrounding area was not provided with enough overlapping light pattern from neighboring fixtures, in the event a resident emergency evacuation. K 2 2. At 11:25 A.M., the surveyor observed at the egress door identified as # that the fixture contained one-bulb and the next rooftop light fixture was approximately 50' away and the surrounding was not provided with enough light in the event a resident emergency evacuation. An interview was conducted with the Maintenance Director at the time of the observations and he stated that he was unaware of this requirement. NJAC 8:39 - 31.2(e) 19.2.9.1 (Emergency Lighting) K 2 Exit Signage 2012 EXISTING K 2 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 observati	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CA A BUILDING 01 ROVIDER OR SUPPLIER 315524 B. WING ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 2 surrounding area was not provided with enough overlapping light pattern from neighboring fixtures, in the event a resident emergency evacuation. K 281 2. At 11:25 A.M., the surveyor observed at the egress door identified as # that the fixture contained one-bulb and the next rooftop light fixture was approximately 50' away and the surrounding was not provided with enough light in the event a resident emergency evacuation. K 281 An interview was conducted with the Maintenance Director at the time of the observations and he stated that he was unaware of this requirement. K 293 KI 293 Exit Signage 2012 EXISTING K 293 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 K 293 Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) K 293 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/28/21, in the presence of the Maintenance Director, it was determined that the facility falled to propenty	S FOR MEDICARE & MEDICAID SERVICES 9: DEFICIENCIES (X1) PROVIDERUMPLIERCLIA IDENTIFICATION NUMBER: (X2) MULTIFLE CONSTRUCTION A. BUILDING 01 315524 B. WNG STREET ADDRESS, CITY, STATE, 2IP CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 STREET ADDRESS, CITY, STATE, 2IP CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 SUMMAY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PROCEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 surrounding area was not provided with enough overlapping light pattern from neighboring fixtures, in the event a resident emergency evacuation. K 281 Continued From page 2 surrounding area was not provided with enough overlapping light pattern from neighboring fixtures, in the event a resident emergency evacuation. K 281 A. 111:25 A.M., the surveyor observed at the geress door identified as # Surrounding was not provided with enough light in the event a resident emergency evacuation. K 281 A. Interview was conducted with the Maintenance Director at the time of the observations and he stated that he was unaware of this requirement. K 293 NJAC 8:39 - 31.2(e) 19.2.9.1 (Emergency Lighting) K 293 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 NA in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evide	S FOR MEDICARE & MEDICAID SERVICES OMB NC oprestination (x) PROVIDERSUPLIERCIA IDENTIFICIATION NUMBER: (p2) MULTIFIE CONSTRUCTION A BUILDING 01 (x1) CONSTRUCTION A BUILDING 01 315524 B. WING 04 SOUDER OR SUPPLIER STREETADRESS. CITY. STATE, 2P CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 04 SOUDER OR SUPPLIER STREETADRESS. CITY. STATE, 2P CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 04 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILINGY ON LSC DENTIFING INFORMATION) ID PREFIX TAC PROVIDERS PLAN OF CORRECTION (EACH OERCINA AND HEALTHCARE CENTER MOUNT LAUREL, NJ 08054 Continued From page 2 surrounding area was not provided with enough overlappin glipt pattern from neighboring fixtures, in the event a resident emergency evacuation. K 281 K 281 Continued From page 2 surrounding was not provided with enough overlappin glipt pattern from neighboring fixtures as provided with enough operations/Designee with conduction. K 281 Continued From page 2 surrounding was not provided with enough operations/Designee with conduction. K 281 An interview was conducted with the Maintenance Director at the time of the observations and he stated that he was unaware of this requirement. NAC 8:39 - 31.2(e) 19.2.9.1 (Emergency Lighting) Suit Signage CTR(s): NFPA 101 Exit Signage CTR(s): NFPA 101 Exit Signage CTR(s): NFPA 101 Exit Signage CTR(s): NFPA 101 Exi

Facility ID: NJ03015

If continuation sheet Page 3 of 12

PRINTED: 11/19/2021 FORM APPROVED

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315524	B. WING		04/28/2021
IAME OF PF	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	· · ·
		N AND HEALTHCARE CENTER		3718 CHURCH ROAD	
				MOUNT LAUREL, NJ 08054	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLE
K 293	Continued From page	e 3	К 29	3	
	nor a way of exit acce		1123	conclusion set forth in the State	ement of
	-	/ to be mistaken for an exit		Deficiencies. This plan of corre	
		sign in accordance with		prepared and/or executed beca	
	NFPA 101, 2012 Edit 7.10.8.3.	ion, Section 7.10 and		provisions of Federal and State require it.	Laws that
	The deficient practice	was evidenced by the		1.Areas identified in the Statem	nent of
	following:			Deficiencies (SOD) as having r	
	-			were outfitted with appropriate	
		0:43 A.M., the surveyor		signage. This was completed b	y or before
		or leading into the enclosed did not have a "NO EXIT"		5/14. Please see attachments. 2.All other areas appropriate for	r a na avit
	sign.	did not nave a INO EXT		sign were reviewed by the main	
	olgin			director/designee to ensure pro	
		0:58 AM the surveyor		signage was in place. Anything	
		Center door leading to the		was addressed accordingly. Th	is was
	incorrect sign "NOT A	not an exit and displayed the		completed by or before 5/14. 3.On or before 5/14, the region	al Director
	Incorrect sign NOT P			of Plant Operations/Designee v	
	3. At approximately 1	1:15 A.M., the surveyor		in-service training to the mainte	
	observed that the doo	or in the Medical Records		staff on NFPA 101, Exit Signag	
		ourtyard and did not have a		the requirement to identify door	
	"NO EXIT" sign.			neither an exit nor a way of exi	
	The findings were ver	rified by the Maintenance		and is located or arranged so it be mistaken for an exit shall ha	-
	Director at the times			no-exit sign.	
				4.Audit to be conducted bi-wee	kly by the
		s informed of the deficiency		maintenance director/designee	
	at the Life Safety Coo	de exit conference.		which is neither an exit nor a w	-
	NJAC 8:39-31.2(e)			access and is located or arrang likely to be mistaken for an exit	
				that have no-exit sign. Audit wi	
				conducted for 3 months or until	
				committee deems appropriate.	
				committee will meet monthly.	5/14/21
K 321	Hazardous Areas - E		K 32		

Event ID: J96K21

Facility ID: NJ03015

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						D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION	· · /	E SURVEY PLETED
		315524	B. WING		04	/28/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL E	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 321	Continued From page	2 4	К 32	21		
	Hazardous Areas - E					
		protected by a fire barrier				
		sistance rating (with 3/4 hour				
		n automatic fire extinguishing				
	· ·	e with 8.7.1 or 19.3.5.9.				
		automatic fire extinguishing				
	system option is used	spaces by smoke resisting				
		n accordance with 8.4.				
	•	osing or automatic-closing				
		e nonrated or field-applied				
		do not exceed 48 inches				
	from the bottom of the					
	Describe the floor and					
	19.3.2.1, 19.3.5.9	are deficient in REMARKS.				
	Area	Automatic Sprinkler				
	Separation N/A a. Boiler and Fuel-Fir					
	b. Laundries (larger t					
	c. Repair, Maintenan	,				
		ns (exceeding 64 gallons)				
	e. Trash Collection R					
	(exceeding 64 gallons					
	f. Combustible Storag					
	(over 50 square feet) g. Laboratories (if cla					
	Hazard - see K322)	3311CU 23 0EVEIE				
	,	is not met as evidenced				
	by:					
		n and interview conducted		Preparation and/or execution of t		
		etermined that the facility		of correction does not constitute a		
		doors to rooms in excess of		admission or agreement by the P		
		toring combustible items vith self-closing hardware.		of the truth or the facts alleged, o conclusion set forth in the Statem		
				Deficiencies. This plan of correct		
	This deficient practice	e was evidenced by the		prepared and/or executed because		
	following:		1	provisions of Federal and State L		1

Event ID: J96K21

Facility ID: NJ03015

If continuation sheet Page 5 of 12

		MEDICAID SERVICES					<u> </u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		CONSTRUCTION	· /	E SURVEY PLETED
		315524	B. WING			04	/28/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL E	BROOK REHABILITATIO	N AND HEALTHCARE CENTER			18 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
K 321	Continued From page	e 5	К 32	21			
	1 At 09:54 A M dur	ing a building tour with the			require it.		
		e Director, The surveyor			1.Areas identified in the Statement of		
		b had been converted			Deficiencies (SOD) were outfitted with		
		age area and was not			self-closing hardware on or before 5/10).	
		losure device on the door.			2.All other rooms in excess of 50-squa	re	
		Tables, 2 mattresses,			feet and storing combustibles were		
	plastic planter pot an	d many miscellaneous items.			reviewed for appropriate self-closing	d	
	2 Δt 09·59 Δ M dur	ing a building tour with the			hardware. Nothing noteworthy identifie 3.On or before 5/14, the regional Direc		
	Facility's Maintenance Director, The surveyor of Plant Operations/Designee						
		in-service training to the maintenance					
		ardous storage area and was			staff on NFPA 101, Hazardous Area 🗆		
	-	elf-closure device on the			Enclosure, including the requirement to		
		ained: plastic combustibles,			have self-closing hardware on all room	s in	
	combustible cardboa	•			excess of 50-square feet and storing		
	miscellaneous items.				combustibles. 4.Audit to be conducted bi-weekly by the		
	3 At 10.05 A M dur	ing a building tour with the			maintenance director/ designee on all	le	
		e Director, The surveyor			rooms in excess of 50-square feet and		
	observed resident ro				storing combustibles to ensure they ha	ve	
		ardous storage area was not			self-closing hardware. Audit will be		
	provided with a self-o	losure device on the door.			conducted for 3 months or until QAPI		
		PPE storage and 100 plus			committee deems appropriate. QAPI		
	combustible cardboa	rd boxes.			committee will meet monthly.		
	4. At 10:15 A.M., dur	ing a building tour with the					
		e Director, The surveyor					
		had been converted					
	to a hazardous stora	-					
	•	losure device on the door.					
	The room contained:						
	full plastic bags of mi	ee reclining chairs and many scellaneous items.					
	5. At 10:25 A.M., dur	ing a building tour with the					
	Facility's Maintenanc	e Director, The surveyor					
		had been converted					
	into a hazardous stor	age area and was not					

Facility ID: NJ03015

If continuation sheet Page 6 of 12

		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 01	CONSTRUCTION		E SURVEY IPLETED
		315524	B. WING		04/28/2021	
NAME OF P	ROVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	DE	
LAUREL I	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		18 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 321	The room contained: cardboard boxes, furn 6. At 10:25 A.M., duri Facility's Maintenanc observed Model into a hazardous stor provided with a self-or The room contained: couch and many mise 7. At 10:35 A.M., duri Facility's Maintenanc observed in the stora resident room #1 that hazardous storage an self-closure device or	losure device on the door. many combustible niture and mattresses. Ing a building tour with the e Director, The surveyor room had been converted age area and was not losure device on the door. chairs, 4- beds, mattresses, cellaneous items. Ing a building tour with the e Director, The surveyor ge room across from t was converted into a rea was not provided with a	K 321			
K 353 SS=D	Director during the ob- was unaware of this r The surveyor verbally Administrator of this f Code exit conference NJAC 8:39-31.2(e) Sprinkler System - M CFR(s): NFPA 101 Sprinkler System - M Automatic sprinkler a	y informed the facility's inding during the Life Safety a, aintenance and Testing aintenance and Testing nd standpipe systems are d maintained in accordance	K 353			5/23/21

Facility ID: NJ03015

If continuation sheet Page 7 of 12

	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION 01	· · ·	E SURVEY PLETED
		315524	B. WING		04	/28/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL E	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 353	Continued From pag	e 7	K 35	3		
		Records of system design,				
	maintenance, inspec					
		re location and readily				
	available.					
	a) Date sprinkler sy	stem last checked				
	b) Who provided sy	stem test				
	c) Water system su	pply source				
	Provide in REMARK	S information on coverage for				
		partial automatic sprinkler				
	system.					
	9.7.5, 9.7.7, 9.7.8, a	nd NFPA 25				
		T is not met as evidenced				
	by:					
		on and interview on 04/28/21,		Preparation and/or execution of this	s plan	
		at the facility failed to ensure tomatic sprinkler system was		of correction does not constitute an admission or agreement by the Pro	vider	
		ondition as evidenced by the		of the truth or the facts alleged, or	videi	
	following:			conclusion set forth in the Statemer	nt of	
	j-			Deficiencies. This plan of correction		
	1. Automatic sprinkle	er heads were not free of		prepared and/or executed because		
		ch could prevent or delay		provisions of Federal and State Lav	vs that	
		2:15 PM, during a tour of the		require it.		
		presence of the facility's		1 Duilding oprinkler ovetem erece		
		r, the surveyor observed 5 of heads located in front of the		1.Building sprinkler system areas identified in the Statement of Deficie	ancies	
		machine and clothes dryer		(SOD) as not being maintained in a		
	•	avy amount of lint on the		condition were fixed. Please see		
	sprinkler heads.			attachment.		
				a.The sprinkler heads with decay an		
		ance Director was unaware		paint are being replaced by contrac	tor on	
	interview during the	acknowledge such in an		or before 5/23. b.The penetrations identified in SOI) were	
				fixed by the maintenance		
	2. One automatic fire	e sprinkler head, behind the		director/designee on 4/28.		
		s dryers had paint on the		c.The North System Gong identified	l in the	
	head.			SOD was fixed by the fire safety ve		

Facility ID: NJ03015

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/19/20 MAPPROVE 0.0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		CONSTRUCTION		E SURVEY PLETED
		315524	B. WING			04	/28/2021
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
		N AND HEALTHCARE CENTER		37	18 CHURCH ROAD		
		AND NEALMOARE OFFICE		Μ	OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 353	Continued From page	e 8	K 35	53			
					on 4/28.		
	-	ance Director was unaware			2.		
	of this condition and interview during the c	acknowledge such in an			a.All other sprinklers were audited to ensure their integrity. This was compl	latad	
		on 4/28 by the maintenance staff.					
	3. In the Activities roo	om a 2' x 2' ceiling tile was			b.All areas were audited to ensure the	ere	
		rinkler head was within 4 feet			were not any penetrations. Nothing		
		ning would now allow hot			remarkable was noted. This was		
	gasses and smoke pa	ast the sprinkler into the			completed on 4/28 by the maintenand staff.	ce	
					c. All facility sprinkler system was	stem was	
	The facility's Mainten	ance Director was unaware			audited, including the gongs, and fou	nd to	
		acknowledged such in an			be in good working order. This was		
	interview during the c	observation.			completed on 4/28 by the maintenand	ce	
	1 The facility provide	ed documentation dated			staff. 3.		
		ire Sprinkler vendor. The			a.On or before 5/14, the regional Dire	ector	
	document indicated u				of Plant Operations/Designee will cor		
		ot working, should be			in-service training to the maintenance		
	serviced."				staff on maintaining the sprinkler syst		
	The facility's Mainten	ance Director was aware of			in good working order, including keep the sprinkler heads free of debris and	-	
	-	licated that the fire sprinkler			dust, keeping the gogs in workable or		
	vendor was short of r	manpower and would			and ensuring there aren □t any fire-sa		
	respond as soon as p	possible to repair the "			penetrations.		
	".				4. a.An audit will be conducted the		
	The facility's Mainten	ance Director was verbally			a.An audit will be conducted the maintenance director/designee month	nlv	
		ng during the Life Safety			on the sprinkler system to review the	,	
	Code exit conference				integrity of all sprinkler heads. Result		
					these audits will be presented to the		
	NFPA 25				committee who will decide duration or audits.	t the	
	NJAC 8:39-31.2(e)				b.An audit will be conducted by the		
					maintenance director/designee month	nly to	
					ensure all ceiling tiles are in place.	-	
					Results of these audits will be presen		
					to the QAPI committee who will indicate the duration of the audits.	ate	

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				CONSTRUCTION				
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 0	E CONSTRUCTION		E SURVEY PLETED		
		315524	B. WING		04	/28/2021		
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE				
LAUREL B	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE		
K 353	Continued From page	e 9	K 353	c.The facility sprinkler system, includ the gongs, will be audited monthly, fo months, to ensure they are in good working order. Results of these findir will be reported to the QAPI committe The QAPI committee will meet month	or 5 ngs ee.			
K 918 SS=E	-	Essential Electric Syste	K 918			5/14/21		
	and associated equip service within 10 sec criterion is not met du process shall be prov capability for the life s Maintenance and tes transfer switches are with NFPA 110. Generator sets are in under load 30 minute day intervals, and exe months for 4 continue under load conditions simulated cold start a transfer of all EES loa competent personnel stored energy power accordance with NFP circuit breakers are in program for periodica components is establ manufacturer require maintenance and tes readily available. EES circuits are marked, r	er alternate power source oment is capable of supplying onds. If the 10-second uring the monthly test, a rided to annually confirm this safety and critical branches. ting of the generator and performed in accordance spected weekly, exercised as 12 times a year in 20-40 ercised once every 36 bus hours. Scheduled test include a complete and automatic or manual ads, and are conducted by . Maintenance and testing of sources (Type 3 EES) are in PA 111. Main and feeder aspected annually, and a ally exercising the						

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		MEDICAID SERVICES			OMB NO. 0938-
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED
		315524	B. WING		04/28/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LAUREL I	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION (X5
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
K 918	Continued From page	e 10	K 91	8	
		age of the emergency power			
	source is a design co	nsideration for new			
	6.4.4, 6.5.4, 6.6.4 (NI 111, 700.10 (NFPA 70	FPA 99), NFPA 110, NFPA			
	This REQUIREMENT	∫ is not met as evidenced			
	by: Based on document	ation review and interview on		Preparation and/or execution of the	is plan
		ence of the Maintenance		of correction does not constitute an	•
		mined that the facility failed		admission or agreement by the Pro	vider
		eded by their generator to		of the truth or the facts alleged, or	
	-	building was within the		conclusion set forth in the Stateme	
	-	imeframe in accordance		Deficiencies. This plan of correctio	
	generator systems.	n emergency electrical		prepared and/or executed because provisions of Federal and State Law	
	This deficient practice	e was evidenced by the		require it.	
	following:	e was evidenced by the		1.The generator identified in the	
	lonoming.			Statement of Deficiencies (SOD) w	as
	At 10:30 a.m., a revie	ew of the facility's generator		reviewed to ensure that the time ne	
		n documentation for both		to transfer power to the facility was	
	generators revealed	the following:		the required 10 second timeframe i	
	A review of the gene	rator records for the		accordance with NFPA 99. This wa certified by the maintenance	S
		revealed that there was no		director/designee on 4/29.	
		tion that the generator would		2.All facility generator systems wer	e
		ver to the building within 10		inspected to ensure they are in	
	seconds.			compliance with capability of supply	ying
				service within 10 seconds.	
	In an interview, at 11	•		3. The maintenance director/design	
		r stated that there were no n the current logs, indicating		provided with in-service education testing and certifying the facility get	
		start and transfer power to		system to ensure it has the capabil	
	the building within 10	•		supplying service within 10 second	
				was done by the regional director of	
	NJAC 8:39-31.2(e), 3	31.2(g)		operations on or before 5/12.	
	NFPA 99			4.The Maintenance Director/design	
				review the generator records month	
				ensure that there was documentation	

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		0.00		
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED
	315524	B. WING		04/28/2021
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BROOK REHABILITATIO	ON AND HEALTHCARE CENTER			
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE COMPLETION
Continued From page	ge 11	K 918	certifying that generator would star transfer power to the building within seconds. Results will be reported to QAPI committee for follow up. The committee will determine duration of audit based on outcomes of the au	n 10 o the of the dits.
	SUMMARY S (EACH DEFICIEN REGULATORY OF	F CORRECTION IDENTIFICATION NUMBER: 315524 315524 ROVIDER OR SUPPLIER BROOK REHABILITATION AND HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING 315524 B. WING ROVIDER OR SUPPLIER B. WING BROOK REHABILITATION AND HEALTHCARE CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 315524 B. WING

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