DEPART	MENT OF HEALTH	AND HUMAN SERVICES	FORM APPROVED						
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0		0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			Сом	E SURVEY IPLETED		
		315524	B. WING				C 16/2024		
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	5	STREET ADDRESS, CITY, STATE, ZIP CODE				
		ATION AND HEALTHCARE CENTE		;	3718 CHURCH ROAD				
LAUREL	BROOK REHABILITA	RION AND HEALTHCARE CENT			MOUNT LAUREL, NJ 08054				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 000	INITIAL COMMEN	TS	FC	000					
		175388, 175449, 175708, 77069, 177592, 177765							
	Survey Date: 10/8/2	24 to 10/16/24							
	Census: 206								
	Sample: 38 + 3 closed records								
	A Recertification/LSC survey was conducted at Laurel Brook Rehabilitation and Healthcare Center from 10/8/24 through 10/16/24, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities.								
Immediate Jeopard CFR 483.25(d)(1) ensure their smoki implemented to red residents who smo resident safety. Th #144 was found will on three occasions		ith Resident #144 on 10/9/24, resident <mark>NJ EX Order 26.4(b)(1)</mark> in last time being that morning							
	had a history of NJ f and that the resider NJ Ex Order 26.4(b)(⁷ onto their ^{NJ Ex Order 26.4(b)(⁷}								
		was informed of the F 689 IJ he IJ template on 10/9/24 at							
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE		
Electron	ically Signed						11/10/2024		

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X) POTE SUPPLIER 15524 (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVEY COMPLETED C NAME OF PROVIDER OR SUPPLIER 315524 B. WING C LAUREL BROCK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 TO 10/16/2024 (M1) D PREFX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTIVA ATTON SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY C00 0METERN DATE F 000 Continued From page 1 5:13 PM. F 000 F 000 An acceptable Removal Plan (RP) was received on 10/10/14 at 9:51 AM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: the resident was placed on 10/10/24, and determined the LJ for F 089 was re-educated on 10/10/124 at 1:11 PM. F 584 Safe/Clean/Comfortable/Homelike Environment. The survey team verified the RP on-site on 10/10/24, and idetermined the ID for F 089 was removed as of 10/10/24 at 1:11 PM. F 584 Safe/Clean/Comfortable/Homelike Environment. The resident thas a right to a safe, clean, F 584
10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AVAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE JUNIMARY STATEMENT OF DEFICIENCIES DEFICIENCE SUMMARY STATEMENT OF DEFICIENCIES PREFIX SUMMARY STATEMENT OF DEFICIENCIES D PREFIX EACH OFFICIENCY WITH BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PATE CORPECTIVE ACTION SHOULD BE (CACH OFFICIENCY WITH BE PRECEDED TO THE APPROPRIATE DEFICIENCY) COMPLETION (EACH OFFICIENCY WITH BE PRECEDED TO THE APPROPRIATE DEFICIENCY) COMPLETION (EACH OFFICIENCY WITH SHOULD BE (CACH OFFICIENCY) COMPLETION (EACH OFFICIENCY WITH SHOULD BE (CACH OFFICIENCY) COMPLETION (EACH OFFICIENCY WITH SHOULD BE (CACH OFFICIENCY) COMPLETION (EACH OFFICIENCY) COMPLETION (EACH OFFICIENCY) F 000 Continued From page 1 5:13 PM. F 000 F 000 F 000 F 000 S112 DM. An acceptable Removal Plan (RP) was received on 10/10/14 at 9:51 AM, indicating the action the facility will conduct routine serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: the resident was placed on NU EX Order 20:401 TE; the resident was removed as of 10/10/24 at 1:11 PM. F 584 State Clean (Chernol Completic) and they relinquished their smoking materials; a smoking evaluation was completed; and the facility will conduct routine safety rounds on Resident #144's room.
3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 (xi) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION BY (EACH OCRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 000 Continued From page 1 5:13 PM. F 000 F 000 F 000 F 000 An acceptable Removal Plan (RP) was received on 10/10/14 at 9:51 AM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: the resident was re-educated on the facility's smoking policy and they relinquished their smoking materials; a smoking evaluation was completed; and the facility will conduct routine safety rounds on Resident #144's room. F 584 11/21/24 F 584 SaFe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i) (3afe Environment. F 584 11/21/24
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMPLÉTION DATE F 000 Continued From page 1 5:13 PM. F 000 F 000 F 000 F 000 F 000 Image: Complete the preceduation of the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: the resident was placed on NJ EXCORDEr 26401 F 000 Image: Complete the preceduation of the facility's smoking policy and they relinquished their smoking materials; a smoking evaluation was completed; and the facility will conduct routine safety rounds on Resident #144's room. F 584 F 584 11/21/24 F 584 SS=F Safe/Clean/Comfortable/Homelike Environment. F 584 11/21/24
5:13 PM. An acceptable Removal Plan (RP) was received on 10/10/14 at 9:51 AM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: the resident was placed on NJ EX Order 26:451 (the resident was placed on the facility's smoking policy and they relinquished their smoking materials; a smoking evaluation was completed; and the facility will conduct routine safety rounds on Resident #144's room. The survey team verified the RP on-site on 10/10/24, and determined the IJ for F 689 was removed as of 10/10/24 at 1:11 PM. F 584 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) F 584
on 10/10/14 at 9:51 AM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: the resident was placed on NJ EX Order 20:401 ; the resident was re-educated on the facility's smoking policy and they relinquished their smoking materials; a smoking evaluation was completed; and the facility will conduct routine safety rounds on Resident #144's room. The survey team verified the RP on-site on 10/10/24, and determined the IJ for F 689 was removed as of 10/10/24 at 1:11 PM. F 584 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. F 584
THE RESIDENT HAS A HUNLIO A SALE. CIERN.

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		ONSTRUCTION	(X3) DATE	SURVEY PLETED
		315524	B. WING			10/1	C 16/2024
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	10/	0/2024
				3718	CHURCH ROAD		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	-R	MOU	JNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	Continued From pa or theft.	ge 2	F 58	84			
		ekeeping and maintenance to maintain a sanitary, orderly, erior;					
	§483.10(i)(3) Clean in good condition;	bed and bath linens that are					
		e closet space in each pecified in §483.90 (e)(2)(iv);					
	§483.10(i)(5) Adequ levels in all areas;	uate and comfortable lighting					
	levels. Facilities init	ortable and safe temperature ially certified after October 1, a temperature range of 71 to					
	sound levels. This REQUIREMEN by:	e maintenance of comfortable NT is not met as evidenced					
	other facility docum	7765; NJ177069 on, interview, and review of entation, it was determined d to maintain the resident		R rc ha	1. The IDT met about the resident Room and the constant of the resident oom was deep cleaned on10/10/24 has been maintained since. The IDT met about Resident #81 or	ned the 1 and	
		ment and living areas in a		1' m	1/6/24 and determined repairs wernade and no other homelike issue been identified.	e	
	resident units (^{Wexone} Wexoner204(0) and was ev	videnced by the following:		ni ci cc	Resident #123 was evaluated by light ourse with NJ Ex Order 26.4(b)(1) related ited event noted. Resident #123 ai conditioner unit filter was changed a emoved from window on 10/30/24	l to r and	
		tour of the facility on 10/8/24			/laintenance Department. The IDT team met to discuss reside	ents	

Facility ID: NJ03015

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			FORM OMB NO.	03/31/2025 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	IPLE CONSTRUCTION	Сом	E SURVEY PLETED
		315524	B. WING			
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP		
LAUREL	BROOK REHABILITA	ATION AND HEALTHCARE CENTI	ER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 584	Continued From pa	ige 3	F 58	34		
	observed the follow -Room 64-A: the ai unidentified black d	-		room change post room tra Resident, # 191, indicates with with current living envir further concerns.	NJ Ex Order 26.4(b)(1)	
	of dust. During an interview at 4:14 PM, in the p the U.S. FOIA (b) (Stated that maintenance shoul cleaned and remain 2.) During a tour on Necosities Unit, the su -Room 201: dust or AC unit -Room 204: the ins brown paint peeling	with the surveyor on 10/15/24 oresence of the survey team, (a) housekeeping and d ensure the AC units were ned dust free weekly. (a) 10/9/24 at 8:34 AM of the urveyor observed the following: (b) the front cover of the window (c) the bathroom door had		Unit Room 64-A: the air condition was cleaned to include the unidentified black discolorative vent grill and the dust from the front Unit Room 201: was cleaned to removal of dust on the front window AC unit -Room 204: the inside of th door was scraped and pain further areas of peeling not -Room 205: was cleaned to removal of dust on the front window AC unit -Room 205: was cleaned to removal of dust on the front window AC unit -Room 211: the inside of the	removal of the ations on the of the AC unit. include the it cover of the be bathroom ated with no ted. o include the it cover of the	
	AC unit -Room 211: the insi brown paint peeling -Room 212: dust or air conditioner (AC) -Room 214: dust or AC unit -Room 218: dust or AC unit, napkins str side of the Window from coming into th -Room 219: observ propped against the visible red colored a -Room 223: the insi brown paint peeling	ide of the bathroom door had off. In the front cover of the window off. In the front cover of the window of the front cover of the window uffed into open area on the AC unit to prevent outside air is room. The an uncovered mattress is wall and a cabinet with spots on the mattress ide of the bathroom door had		door was scraped and pair further areas of peeling not -Room 212: was cleaned to removal of dust on the from window air conditioner (AC -Room 214: was cleaned to removal of dust on the from window AC unit -Room 218: was cleaned to removal of dust on the from window AC unit, napkins st area on the side of the Window prevent outside air from coming int removed, ac unit is in work window unit was removed	ated with no ted. o include the t cover of the) unit. o include the t cover of t cover of t cover t cover t cover of t cover t cover t cover of t cover t co	

Facility ID: NJ03015

		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		E CONSTRUCTION	Сом	E SURVEY PLETED
		315524	B. WING	i			
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefi Tag		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 584	Continued From pa	ao 1		584			
1 304	AC unit	ge 4	Г	004	on 10/30/24.		
	AC unit				-Room 219: the observed an uncov	ered	
	During an interviw v	with the surveyor on 10/15/24			mattress	ci cu	
		. FOIA (b) (6)), in			propped against the wall was remo	ved	
	the presence of the	survey team stated that he			and discarded. The cabinet was cle		
	will check if any maintenance orders were placed for the peeling paint. The sector did not bring any				-Room 223: the inside of the bathro		
	additional information regarding the paint.				door was scraped and painted with	no	
	additional informatio	on regarding the paint.			further areas of peeling noted. -Room 224: was cleaned to include	the	
	On 10/15/24 at 3.06	at 3:06 PM, the surveyor interviewed			removal of dust on the front cover of		
	the U.S. FOIA (b) (6) and the				window AC unit		
	U.S. FOIA (b) (6)) in the presence of the				NJ Ex otder 25.40 Unit		
	survey team. The	stated that floor mats and			-The identified yellow tape on the h		
	mattresses should	be cleaned.			floor in multiple		
					areas were removed -The identified area with the flooring	a otrip	
	3) During the initial	tour on 10/8/24 at 10:35 AM			partially raised off the floor was	y suip	
		the surveyor observed the			appropriately secured.		
	following:				On 10/9/24 at 2:19 PM, during a su	rveyor	
	•				visit to		
	-Yellow tape on the	hallway floor in multiple areas.			Room was cleaned by houseke	eeping	
					on 10/9/24 to include removal of the		
		ng was partially raised off of			hardened brown substance on the		
	the floor.				and removal of empty clear manufa packaging, an empty carboard juice		
	On 10/9/24 at 2.19	PM, during a surveyor visit to			wrapping, and small debris were no		
	Room a resider following was obser	ent occupied room, the			the floor near the resident's bed.		
					NU EX Order 25.4() Unit		
		substance on the resident's			Room The identified area wit		
	floor.				hole in the ceiling was appropriately repaired, including removing the cle		
	During an interview	with the surveyor, the			plastic surrounded by black electric		
		stated, "my room has not			tape.		
	been cleaned in a c						
		·			The identified PTAC (packaged ter		
		33 PM, the surveyor returned			air conditioner unit) was repaired a	nd is in	
		he hardened brown substance			working order free of dents and/or		
	was still on the resid	dent's floor. An empty clear			damage.		

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		& MEDICAID SERVICES		PLE CONSTRUCTION	MB NO.	E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		IG	Сом	PLETED
		315524	B. WING		С	
	PROVIDER OR SUPPLIER	515524	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	10/	16/2024
		ATION AND HEALTHCARE CENTE	ER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
				PROVIDER'S PLAN OF CORRECTION		015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE	(X5) COMPLETION DATE
F 584	Continued From pa	ige 5	F 58	4		
	manufacture packa	ging, an empty carboard juice		Room	de the	
		Il debris were noted on the		removal of dust from the outside of		
	floor near the resid			vent cover of the identified wall un conditioner.	it air	
	On 10/15/24 at 3:00	6 PM during an interview with				
	the surveyor in the	presence of the ^{U.S. FOIA(b)(6)}) and the survey team, the		Room Commercial Commercial Room on the ceiling was repaired. Roor	d area	
	U.S. FOIA (b) (6)) and the survey team, the		the identified NJ Ex Order 26.4(b)(1		
		dent rooms were cleaned daily		including the wheels was cleaned		
		e tray tables, high touch areas,		sanitized to be free of dust, debris		
		re, and floors. When asked		hardened, dried, spillage noted or		
		substance stuck on the floor,				
		e usually spray, then we have		The three (3) geriatric chairs ident		
	scrappers for anyth	ing that is stuck to the floor."		the hallway were cleaned, and we		
	4) During the initial	l tour on 10/8/24 from 10:55		resident use, were removed from areas until picked up by the hospi		
		Unit, the surveyor		provider.		
	observed the follow			The covering of the identified liner	n cart	
		c .		was replaced and is free from tea		
		was a hole in the ceiling that		The identified AC unit in the		
		lear plastic surrounded by		activities/dining room was cleaned	and the	
		e. There was a dried		cover replaced.		
		the center of the plastic that the ceiling. A PTAC		The middle window including the windowsill was cleaned with no du	et	
		air conditioner unit) had a		debris, and/or cobwebs further no		
		damaged front cover, and a		The AC unit in the window in the f		
		oner unit that was vented out of		the room was cleaned to include t	he	
		ow were both in the room.		removal of dust and cobwebs.		
		nis/her spouse were present				
		iling should not be that way, t way since around ^{NJ Ex Order 20.4(5)(1)}		2. Current residents have the po		
		c up in the early part of the		be affected. An audit was comple resident rooms and resident comr		
		it would have been fixed by		areas to validate		
		s spouse stated that he/she		Safe/Clean/Comfortable/Homelike	÷	
	mentioned it to mai	ntenance previously, who		Environment is maintained to inclu		
	stated that they wo	uld come back and fix it.		not limited to the need ac units an		
				windows are free from dust, disco		
		Il unit air conditioner had a		debris are cobwebs. Bathroom do		
	thick coating of dus	t on the outside of the vent		free of peeling paint. PTAC are in	gooa	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLER 315524 (X2) PROVIDER COMPLETED 315524 (X2) PROVIDER STATE VERVEY A BUILDING (X2) PROVIDER STATE VERVEY 316 CURCH ROAD 3178 CU			AND HUMAN SERVICES				FORM	: 03/31/2025 APPROVED : 0938-0391
315524 B. WINC 10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 3716 CHURCH ROAD LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, 2P CODE 3716 CHURCH ROAD WHE OF PROVIDERS OF REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, 2P CODE 3716 CHURCH ROAD WHE OF PROVIDERS OF REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, 2P CODE 3716 CHURCH ROAD WHE OF PROVIDERS OF NEW WITH AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, 2P CODE 3716 CHURCH ROAD WING SUMMARY STATEMENT OF DEFICIENCIES PRETX REGULATORY OR LSC DENTIFYING BRECEDED BY FULL FERM Commental Streem Carlon SHOULD BE COMPERPORTATE DUF A 12 20 FM, Certified Nursing Assistant (CNA) #46 stated that if se noted anything in need of repair shold the nurse and proteinal shoed anything in need of repair, she placed an anintenance call and the y tesponded within thirty minutes. LPN #9 further stated that the when she noted something in need of repair, she placed an anintenance call and the y tesponded within thirty may have taken a vent out of room the scaled in the surveyor on 10/9/24 at 12:32 FM. Licensed Practical Nurse/UNI #4 stated that he would notify maintenance or housekeeping and nursing staff on flexibly policy for throrough evaluation of equipment, resident rooms and common area for repairs and the process for reporting to facilitathy policy for throrough evalua				1 ° ′			COMPLETED	
NAME OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STRITZ, ZIP CODE JAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STRITZ, ZIP CODE JAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STRITZ, ZIP CODE JAUREL BROOK REHABILITATION AND HEALTHCARE CENTER D JAUREL BROOK REHABILITATION AND HEALTHCARE CENTER D JAUREL BROOK REHABILITATION AND HEALTHCARE CENTER D JAUREL AND OCORRECTION CENTER CORRECTION RECORDER YOULL PROVUERS PLAN OF CORRECTION CORRECTION CENTER CONTROL OF CARDS AREFREENCED TO THE APPROPRIATE DECORDER YOULL JAURE AND			315524	B. WING	÷		-	
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER MOUNT LAUREL, NJ 98954 (%) ID PRETIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTIVE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLET (COMPLET) F 584 Continued From page 6 cover. F 584 F 584 F 584 Continued From page 6 cover. F 584 During an interview with the surveyor on 10/9/24 at 12:20 PM. Certified Nursing Assistant (CNA) #Ø stated that ifs he noted anything in need of repair, she tokic the hole in the ceiling and saw the tape in Room main and figured that it was being taken care of. F 584 F 614(10)(3) JUSTEDIATION (B appropriately. Variances were addressed. 3. The Regional Plant Operations Assistant/designee re-educated the US: FOIA(10)(3) JUSTEDIATION (B appropriately. Variances were addressed. 3. The Regional Plant Operations Assistant/designee re-educated the US: FOIA(10)(3) JUSTEDIATION (B and/or repairs and the process for reporting to facilitate timely remediation. The housekeeping and nursing staff on Identifying areas requiring cleaning and/or repairs and the process for reporting to facilitate timely remediation. The housekeeping and bance con the facility policy for thorough cleaning and samitation along with the cleaning schedules. The maintenance or thousekeeping. During an interview with the surveyor on 109/24 at 12:35 FM. Resident #123 stated that the surveyor on 109/24 at 12:35 FM. Resident #123 stated that he/she had not seen the air conditioner unit Tilter changed or cleaned since he/she was admitted to the facility po	NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFix TAG CEACH CORRECTIVE ACTIONS HOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY Commention Commention F 584 Continued From page 6 cover. F 584 F 584 F 584 F 584 During an interview with the surveyor on 10/9/24 at 12:20 PM, Certified Nursing Assistant (CNA) #Ø stated that if she noted anything in need of repair she told the nurse and put a maintenance request into the system. (CNA #Ø further stated that she noticed the hole in the ceiling and saw the tape in Room IIII and figured that it was being taken care of. F 584 During an interview with the surveyor on 10/9/24 at 12:25 PM, Licensed Practical Nurse (LPN) #9 stated that when she noted something in need of repair, she placed a maintenance call and they responded within thirty minutes. LPN #9 thurther stated, "I think that they may have taken a vent out of room IIIII PM 9 stated that she would follow-up with maintenance. F 584 During an interview with the surveyor on 10/9/24 at 12:32 PM, Licensed Practical Nurse (LPN) #9 stated find then surveyor on 10/9/24 at 12:32 PM, Licensed Practical Nurse/Unit Manager (LPNUM) #4 stated that she would follow-up with maintenance. F 584 During an interview with the surveyor on notice the air conditioner units. It has to be cleaned." LPNUM/W #4 stated that he/she had not seen the air conditioner unit filter changed or cleaned since he/she was admitted to the facility. F 684 Staff reducation was provided to ensure the environment is kept clean and maintenance check schedules. During an interview with the surveyor on 10/9/24 at 10.70 FM, LPNUM #4 stated that he/she had not seen the air conditio	LAUREL	BROOK REHABILITA	ATION AND HEALTHCARE CENTE	R	I			
 cover. During an interview with the surveyor on 10/9/24 at 12:20 PM, Certified Nursing Assistant (CNA) #8 stated that if she noted anything in need of repairs he told the nurse and put a maintenance request into the system. CNA #8 further stated that she noted the hole in the ceiling and saw the tape in Room and figured that it was being taken care of. During an interview with the surveyor on 10/9/24 at 12:25 PM, Licensed Practical Nurse (LPN) #9 stated that when she noted something in need of repair, she placed a maintenance call and they responded within thirty munites. LPN #9 further stated, "I think that they may have taken a vent out of room the LPN #9 stated that she would follow-up with maintenance. During an interview with the surveyor on 10/9/24 at 12:32 PM, Licensed Practical Nurse/Unit Manager (LPN/UM) #4 stated that he would notify maintenance drug that she to be cleaned. "LPN/UM #4 stated that he/she had not seen the air conditioner runt filter changed or cleaned since he/she was admitted to the facility. During an interview with the surveyor on 10/9/24 at 1:2:35 PM, Licensed Practical Nurse/Unit Manager (LPN/UM) #4 stated that he/she had not seen the air conditioner runt filter changed or cleaned since he/she was admitted to the facility. During a later interview with the surveyor on 10/9/24 at 1:07 PM, LPN/UM #4 stated that he did not see a hole in the ceiling in rcom Minutes and the stated that he did not see a hole in the ceiling the compassion of the facility. During a later interview with the surveyor on 10/9/24 at 1:07 PM, LPN/UM #4 stated that he did not see at hele in the ceiling in rcom Minutes and the stated that he did not see a hole in the ceiling the row more manatome taken and the repairs are the air conditioner unit filter changed or cleaned since he/she was admitted to the facility. During a later interview with the surveyor on 10/9/24 at 1:07 PM, LPN/UM #4 stated that he did not see a hole in the ceiling in rc	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE	ULD BE	COMPLETION
 During an interview with the surveyor on 10/9/24 at 12:20 PM, Certified Nursing Assistant (CNA) #8 stated that if she noted anything in need of repair she told the nurse and put a maintenance request into the system. CNA #8 further stated that she noticed the hole in the ceiling and saw the tape in Room and figured that it was being taken care of. During an interview with the surveyor on 10/9/24 at 12:25 PM, Licensed Practical Nurse (LPN) #9 stated that she noted something in need of repair, she placed a maintenance call and they responded within thity minutes. LPN #9 further stated, "I honset add that she would follow-up with maintenance. During an interview with the surveyor on 10/9/24 at 12:32 PM, Licensed Practical Nurse/Unit Manager (LPN/UM) #4 stated that he would notify maintenance or housekeeping. During an interview with the surveyor on 10/9/24 at 12:35 PM, Resident #123 stated that he/she had not seen the air conditioner unit filter changed or cleaned since he/she was admitted to the facility. During a later interview with the surveyor on 10/9/24 at 1:07 PM, LPN/UM #4 stated that he would notify maintenance e housekeeping. During a later interview with the surveyor on 10/9/24 at 1:07 PM, LPN/UM #4 stated that he did not see a hole in the ceiling in room 10/9/24 at 1:07 PM, LPN/UM #4 stated that he did not see a hole in the ceiling in room 10/9/24 at 1:07 PM, LPN/UM #4 stated that he did not see a hole in the ceiling in room 10/9/24 at 1:07 PM, LPN/UM #4 stated that he did not see a hole in the ceiling in room 10/9/24 at 1:07 PM, LPN/UM #4 stated that he did not see a hole in the ceiling in room 10/9/24 at 1:07 PM, LPN/UM #4 stated that he did not see a hole in the ceiling hi room 10/9/24 at 1:07 PM, LPN/UM #4 stated that he did not see a hole. The relives probably 	F 584	Continued From pa	ige 6	F	584			
		cover. During an interview at 12:20 PM, Certifi #8 stated that if she repair she told the r request into the sys that she noticed the the tape in Room being taken care of During an interview at 12:25 PM, Licen stated that when sh repair, she placed a responded within th stated, "I think that out of room Buring an interview at 12:32 PM, Licen Manager (LPN/UM notice the air condi cleaned." LPN/UM maintenance or how During an interview at 12:35 PM, Resid had not seen the ai changed or cleaned the facility. During a later interv 10/9/24 at 1:07 PM not see a hole in th	with the surveyor on 10/9/24 ied Nursing Assistant (CNA) is noted anything in need of nurse and put a maintenance stem. CNA #8 further stated is hole in the ceiling and saw and figured that it was and figured that it was with the surveyor on 10/9/24 ised Practical Nurse (LPN) #9 he noted something in need of a maintenance call and they hirty minutes. LPN #9 further they may have taken a vent LPN #9 stated that she would tenance. with the surveyor on 10/9/24 sed Practical Nurse/Unit) #4 stated, "I honestly did not tioner units. It has to be #4 stated that he would notify usekeeping. with the surveyor on 10/9/24 dent #123 stated that he/she ir conditioner unit filter d since he/she was admitted to view with the surveyor on , LPN/UM #4 stated that he did e ceiling in room		504	repair. Resident room ceilings a repair, IV pole poles are clean to wheels, Geri chairs out in reside are cleaned, in good repair and appropriately. Variances were a 3. The Regional Plant Operation Assistant/designee re-educated U.S. FOIA (b) (6) U.S. FOIA (b) (6) U.S. FOIA (b) (6) U.S. FOIA (c) U.S. FOIA (b) (6) U.S. FOIA (c) I.S. FOIA (c) I.S. FOIA (c) I.S.	b include ent areas stored ddressed. ons the (b) (6) sing staff eaning for ediation. educated ronmental policy for n along ducated enance on valuation nd de d clinical to ensure nd timely as fied in the will dent lidate ike clude mely	
it." LPN/UM #4 further stated, "It was not weeks, then monthly x 2 months. The		attempted to fix it, k	out had to see how to resolve			These audits will be conducted		

Facility ID: NJ03015

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE	ECONSTRUCTION		E SURVEY
D PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG _		СОМ	PLETED
		315524	B. WING				C 16/2024
IAME OF F	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2024
AUREL	BROOK REHABILIT	ATION AND HEALTHCARE CENT	ER		18 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) Completio Date
F 584	Continued From pa	age 7	F 58	34			
	LPN/UM #4 stated maintenance. During an interview at 11:24 AM, the stated that he had to his attention yes was being patched do weekly walk three did not think that the there and the repair immediately or AS/ At 11:33 AM, the st the condition of the states on states on the housekeeping was	worked at the facility since at he was not sure how long on like that, but it was brought terday by the ^{US FOADION} , and now. The ^{US FOADION} stated that we bughs. The ^{US FOADION} stated that he he plastic should have been irs should have been made			findings of the audits will be subm the Administrator to the QAPI Cor for review and recommendation n for 3 months or ongoing until com is sustained.	nmittee nonthly	
	maintenance clean During an interview at 12:00 PM, Hous she was responsib units. HK #3 stated attention today and purpose cleaner. H important to clean conditioner vents b breathe air from it.	with the surveyor on 10/10/24 ekeeper (HK) #3 stated that le to dust the air conditioning I that her boss brought it to her I the vent was wiped with an all IK #3 stated that it was the outside of the air because the resident's had to The surveyor noted that there emained on the air conditioner					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		315524	B. WING			(10/1	C 16/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	c	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	walking rounds for p stated, "We do mor take notes, and main described the main notes and stated the that staff were requi- During an interview at 3:07 PM in the pr the U.S. FOIA (b) (d air conditioner vents daily and deep clea that she did not exp dust on the outside The states in residents that time, the surve the air conditioner u and after it was rep stated, "They can d 5.) During a tour of 10:29 AM, the surve +Room states in the surve the air conditioner u and after it was rep stated, "They can d 5.) During a tour of 10:29 AM, the surve the patched area th Licensed Practical I at the bedside and s noticed the conditio During an interview at 10:59 AM, the U.	preventative maintenance he e of a visual rounding, they ke repairs." The second tenance notes as personal at there was no official form ired to turn in. with the surveyor on 10/15/24 resence of the survey team, (a) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c	F 58	84			

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION (X3) DATE SURVEY NAME OF PROVIDER OR SUPPLIER (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG PROVIDER'S PLAN OF CORRECTION ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG CONTINUE (PACH DEFICIENCY MUST BE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG F 584 Continued From page 9 F 584 Continued From page 9 F 584 F 584 F 584 Cont			AND HUMAN SERVICES				FORM	APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 315524 B. WING 10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ALAUREL BROOK REHABILITATION AND HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETIN DATE F 584 Continued From page 9 surveyor asked her to clarify what she meant, she stated, "I want to see if it were previously F 584 F 584 F 584				(X2) MULT	TIPL			
NAME OF PROVIDER OR SUPPLIER 315524 B. WING 10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD (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 SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETIC DEFICIENCY F 584 Continued From page 9 surveyor asked her to clarify what she meant, she stated, "I want to see if it were previously F 584 F 584 F 584	AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:					
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) COMPLETIX DATE F 584 Continued From page 9 surveyor asked her to clarify what she meant, she stated, "I want to see if it were previously F 584			315524	B. WING				-
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER 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) COMPLETIVE DATE F 584 Continued From page 9 surveyor asked her to clarify what she meant, she stated, "I want to see if it were previously F 584 F 584 F 584	NAME OF F	PROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLÉTIC DATE F 584 Continued From page 9 surveyor asked her to clarify what she meant, she stated, "I want to see if it were previously F 584	LAUREL	BROOK REHABILITA	ATION AND HEALTHCARE CENTE	ER				
surveyor asked her to clarify what she meant, she stated, "I want to see if it were previously	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			FIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
During an interview with the surveyor on 10/10/24 at 11:30 AM, the surveyor and the interview wet to room interview the ceiling together. The interview istated, "I see buckling here and we have to immediately address it and get the resident out of the room." The IUS: F0/16(0)(6) was present and stated that the area looked like it was previously patched. The interview was the surveyor on corring to me. We cannot let it go on." During an interview with the surveyor on 10/15/24 at 2:37 PM, the interview with the surveyor on 10/15/24 at 2:37 PM, the interview address it and get the resident out of the cause of the ceiling damage in room interview with the surveyor observed the following: 6.) During the initial tour on 10/8/24 at 10:34 AM of the interview (Interview) observed the following: In room interview in the surveyor observed the following: At 1:07 PM the surveyor observed the following in the interview of the ceiling upright) that had debris on the chair. One (1) of the geri-chair - used for those with mobility issues and have difficulty sitting upright) that had debris on the chairs. One (1) of the geri-chairs had a tear on the right arm rest.	F 584	surveyor asked her stated, "I want to se addressed." During an interview at 11:30 AM, the su room stated is to view t stated, "I see buckli immediately address the room." The U.S was present looked like it was pr stated, "It was very let it go on." During an interview at 2:37 PM, the stated, "It was very let it go on." During an interview at 2:37 PM, the stated it was of the 6.) During the initial of the cause of the 6.) During the initial of the surver of the cause of the NJ Ex Order 26.4(b) hardened, dried, sp stated dust an At 1:07 PM the surve the surver chairs (geri-chair - u issues and have dif debris on the back of	with the surveyor on 10/10/24 urveyor and the serve went to the ceiling together. The server ing here and we have to as it and get the resident out of FOIA (b) (6) t and stated that the area reviously patched. The server concerning to me. We cannot with the surveyor on 10/15/24 stated that he was unsure ceiling damage in room served the surveyor observed the esident's NJ Ex Order 26.4(b)(1) b)(1) b) had billage on it. The wheels of the ad debris on it. weyor observed the following in re were three (3) geriatric used for those with mobility ficulty sitting upright) that had of the chairs. One (1) of the	F 5	84			

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		AND HUMAN SERVICES				FORM	: 03/31/2025 APPROVED : 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		LE CONSTRUCTION	COM	E SURVEY IPLETED
		315524	B. WING				C 16/2024
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 584	-In the same hallwa black net covering to was torn. -In the activities/din conditioning (AC) un had a brown color r debris. There was r vents. The middle v and had dust, debri windowsill. The AC of the room had dust During an interview at 11:54 AM, LPN # staff was responsib and NJ Exorder 26:4(b)(documented on the Record (TAR) that to During an interview at 11:58 AM, LPN # housekeeping were NJ Ex Order 26:4(b) stated they were cle She further stated to daily, but was not so schedule or where in During an interview at 12:05 PM, CNA # responsible for clear and NJ Exorder 26:4(b) stated they were clear During an interview at 12:05 PM, CNA #	ing room, there was an air nit in the back of the room that hoted on the vents with visible to cover over on AC unit window was partially opened is, and cobwebs noted on the unit in the window in the front st and cobwebs on it. With the surveyor on 10/9/24 9 stated the overnight nursing le for cleaning the stated it was Treatment Administration the machine was cleaned. With the surveyor on 10/9/24 8 stated that both nursing and e responsible for cleaning the stated the toth nursing and e responsible for cleaning the machine was a cleaning the machine was a cleaning it would be documented. With the surveyor on 10/9/24 9 stated the nurses were aning the NEXCOMPTION She eaned weekly and as needed. That the housekeeper wiped it ure if there was a cleaning it would be documented.	F	584			
	at 12:07 PM, the Lie						

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315524	B. WING		(10/*	C 16/2024
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R I	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	spillage in the resid would clean it, but t housekeeping to fo LPN/UM #2 stated was a cleaning sch had seen it, then sh At 12:10 PM, the su LPN/UM #2, who st was a cleaning sch wheelchairs and ge knew they were clean often they were clean the were located. LPN geri-chairs and high hallway were from t stated that the hosp to come pick them During an interview at 12:26 PM, the Ho that housekeeping have time after doir to do." HK #1 stated main areas and not explained if he clean	ent's room then the nurses hen they would call llow up and disinfect it. that she did not know if there edule. She then stated if she he would notify housekeeping. urveyor continued to interview tated she was not sure if there edule for the cleaning of the ri-chairs. She stated that she aned but was unsure of how	F 584			

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						FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION			0938-0391
	FCORRECTION	IDENTIFICATION NUMBER:	` ´	G			PLETED
		315524	B. WING				
NAME OF F	PROVIDER OR SUPPLIER	013324		STREET ADDRESS, CITY, STATE, ZIP CO	DE	10/	16/2024
LAUREL BROOK REHABILITATION AND HEALTHCARE CEN			R	3718 CHURCH ROAD			
			MOUNT LAUREL, NJ 08054				
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S			(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPR	RIATE	DATE
F 584	Continued From pa	ge 12	F 58	4			
	During on interview	with the survey or $10/0/24$					
	at 12:29 PM, the U.	with the surveyor on 10/9/24 S. FOIA (b) (6)					
	stated housekeepin	g and nursing were					
	and the NUEXOTOGET 25.4(0)(ning the NJ Ex Order 26.4(b)(1) e stated that he would have to					
	research to see if th	nere was a cleaning schedule					
		een the us form at the facility for					
		he before stated that even if the hospice the facility was still					
	responsible for clea	ning them. He stated that					
		responsible to clean out any d debris on the windowsill. He					
		ekeeping was also responsible					
	for cleaning the air	conditioners to ensure there					
		ensure everything was clean. was important to keep the					
		as clean to prevent infection					
	and to create a hon	nelike environment.					
	On 10/9/24 at 12:36	6 PM, the ^{us for the} and the					
	surveyor conducted	an environmental tour on the					
		me, the stated the allway were not being used,					
		e areas that needed to be					
	cleaned.						
	At 12:37 PM. the	and the surveyor entered					
	room ^{NJ Ex Orde} . The ^{U.S. FO}	confirmed there were					
		ge from the <mark>NJ Ex Order 26.4(b)(1)</mark> on ^{JEX Order 26.4(t)} . He stated he would					
		requency that equipment was					
		expect it to be clean.					
	At 12:39 PM the su	Irveyor showed the US FOIA(* the					
	linen cart in the hall	way. He stated he was aware					
	of the linen cart and covers but was wait	had ordered replacement					
	COVERS DUL WAS WAI	ung on a shipment.					

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		AND HUMAN SERVICES				FORM	APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG_			
		315524	B. WING _				C 16/2024
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		18 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	1	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 584	At 12:41 PM, the su the activities/dining confirmed the AC u needed to be fixed, dust on and by the windowsill needed to the expectation for allergens. During an interview at 10:41 AM, HK #2 the Motion Unit. He si for cleaning the resi medication room, of manager's room, th pantry, and the sup the resident's room windowsills, handra towel dispenser, sw the nightstands, stated that he tried because they got di looks like I did not e there was no docum daily. HK #2 stated responsible for clean geri-chairs and that When asked how o stated "I am not goi often they were sup further stated he was to track the wheelch stated we was unsu- were from the hosp cleaned anything he geri-chairs in the hat At 10:48 PM, the su	arveyor and the METONE entered room. At that time, the METONE nit in the back of the room and the cobwebs and the air conditioner and in the to be cleaned. He stated it was it to be cleaned to prevent with the surveyor on 10/10/24 e stated that he was mainly on stated that he was responsible ident's rooms, dining room, xygen room, the unit is spa/shower room, the ply room. He further stated in , he cleaned the toilets, iils, soap dispenser, paper /ept and mopped the floors, metode and the METONE to clean the METONE daily irty quick. He further stated, "it even clean it." He explained nentation, but that it was done housekeeping was uning the wheelchair and the did them today, 10/10/24. ften they are cleaned. "He as not sure if there was a log nairs and geri-chairs. HK #2 ure if the chairs in the hallway ice company but that he e saw which would include the	F 58	34	DEFICIENCY)		

Facility ID: NJ03015

If continuation sheet Page 14 of 171

CENTERS FOR MEDICARE & MEDICAD SERVICES CMB NO. 0939-0391 STATEMENT OF DEFORMEDS (I) PROVIDER/SUPPLERCIA (PC) MULTIPLE CONSTRUCTION (PC) DATE SURVEY AND FLAN OF CORRECTION 315524 B. WNO C INME OF PROVIDER OR SUPPLIER 315524 B. WNO STREET ADRESS, CITY, STATE, ZIP CODE AUREL BROCK REHABILITATION AND HEALTHCARE CENTER STREET ADRESS, CITY, STATE, ZIP CODE STREET ADRESS, CITY, STATE, ZIP CODE AUREL BROCK REHABILITATION AND HEALTHCARE CENTER STREET ADRESS, CITY, STATE, ZIP CODE STREET ADRESS, CITY, STATE, ZIP CODE PROVIDERS NAME OF DEFICIENCES PROVIDERS NAME OF CORRECTION Y TAUL D C PROVIDER VALUE STREET ADRESS, CITY, STATE, ZIP CODE STREET ADRESS, CITY, STATE, ZIP CODE PROVIDER VALUE STREET ADRESS, CITY, STATE, ZIP CODE STREET ADRESS, CITY, STATE, ZIP CODE PROVIDER VALUE STREET ADRESS, CITY, STATE, ZIP CODE STREET ADRESS, CITY, STATE, ZIP CODE PROVIDER VALUE STREET ADRESS, CITY, STATE, ZIP CODE STREET ADRESS, CITY, STATE, ZIP CODE PROVIDER VALUE STREET ADRESS, CITY, STATE, ZIP CODE STREET ADRESS, CITY, STATE, ZIP CODE STREET ADRESS, CITY, STATE, ZIP CODE STREET ADRESS, CITY, STATE, ZIP CODE STREET ADRESS, CITY, STATE, ZIP CODE STREET ADRESS, CITY, STATE, STREET ADRESS, CITY, STATE, ZIP CODE STRESTATE, STREET ADRESS, CITY, STATE, ZIP CODE			AND HUMAN SERVICES				FORM	03/31/2025 APPROVED
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Facility ID: NJ03015

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE		(X3) DATE	E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG_			PLETED
		315524	B. WING				C 16/2024
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
F 584	immediately. The sconducted "visual" r official documentati rounds. On 10/15/24 at 3:06 the U.S. FOIA (b) (6 U.S. FOIA (b) (6) survey team. The (HK) were responsi rooms, the wheelch spa/shower rooms of check list on their ca there was nothing of further stated that h conducted weekly a stated that houseke cleaning the window unit daily. She furth department was resp filters. The states filters. The states residents with respi At 3:15 PM, the states	SPM, the surveyor interviewed SPM, the surveyor interviewed	F 58	84			
	in that vicinity."	o get clean with the clientele					
	the pictu	veyor showed the barrent and res from 10/8/24 and 10/9/24. at the expectation was that "it better than that."					
	Disinfection of Resi Equipment", (revise	ity's policy titled "Cleaning and dent-Care Items and ed September 2022), reflected quipment, including items and					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		TE SURVEY MPLETED
ND PLAN C	FORRECTION	IDENTIFICATION NUMBER.					C
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 584	Continued From pa	ge 16	F 5	684			
	disinfected accordin recommendations f Bloodborne pathoge Classification Systel levels of sterilization items used in reside a. Critical items con- risk of infection if co- microorganism. Ob- (e.g. urinary cathete intravenous cathete items and must be b. Semi -critical items come in contact wit intact skin (e.g. res c. Non-critical items contact with intact s membranes, includ- bedpans, blood pre computes. Non- cri include bed rails, be The policy further re are cleaned and dis residents (e.g. steth equipment (DME)). are cleaned and dis single resident and bedpans, urinals). A review of the facil	For disinfection and OSHA ens Standard. The Spaulding em is used to distinguish the n/ disinfection necessary for ent care: asist of items that carry a high pontaminated with any ojects that enter sterile tissue ers) or vascular system (e/g ers) are considered critical sterile. Ins consist of items that may h mucous membranes or non- spiratory equipment). as are those that come in skin but not mucous e resident care items such as ssure cuffs, crutches and itical environmental surfaces edside tables, etc. evealed that reusable items sinfected or sterilized between noscopes, durable medical Single residents use items sinfected between uses by a disposed of afterwards (e.g.					
	August 2019), revea surfaces will be clea according to curren	ronmental Surfaces", (revised aled that environmental aned and disinfected t CDC recommendations for hcare facilities and OSHA					

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		AND HUMAN SERVICES				FORM	: 03/31/2025 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	CON	E SURVEY
		315524	B. WING				C 16/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) Completion Date
F 584	in resident care and environment: A. Critical items of high risk of infection microorganism. Ob (e.g. urinary cathete intravenous cathete items and must be B. B. Semi -critical may come in contact non- intact skin (e. C. Non-critical item contact with skin bu (1), non- critical envi bedrails, some food furniture, and floors The policy further re surfaces (e.g. floors on a regular basis (week) and when vis surfaces will be disi regular basis (e.g. of when surfaces are window curtains in the when these surfaces soiled. A review of the facil Equipment" revised "Resident-care equi disinfected"	d those in the residents onsist of items that carry a if contaminated with any ojects that enter sterile tissue ers) or vascular system (e/g ers) are considered critical sterile. I items consist of items that ct with mucous membranes or g respiratory equipment). ns are those that come in it not mucous membranes. <i>v</i> ironmental surfaces include d utensils, bedside tables,	F 5	84	DEFICIENCY)		
	clean, comfortable	and homelike environment use their personal belongings					

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		AND HUMAN SERVICES			FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		0938-0391
	F CORRECTION	IDENTIFICATION NUMBER:	1 ° '	NG		PLETED
					(С
		315524	B. WING		10/	16/2024
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD			
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER			MOUNT LAUREL, NJ 08054			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
				DEFICIENCY)		
F 584	Continued From pa	ao 18	F 58	24		
1 304	Continued i form pa	ge to	F DC	54		
		d management maximizes, to				
	•	the characteristics of the				
		a personalized, homelike acteristics include: clean,				
	sanitary and orderly					
	A review of an unda	ated facility policy				
		ids Policy" revealed the				
	following: Maintena	nce Staff will conduct daily				
		e center's environment is safe m throughout the center.				
		ccur every 2-3 hours while				
	work orders checke					
	Procedures: Mainte	nance staff will conduct				
		the center daily to address				
	any emergencies a	nd work orders.				
	The Maintenance	Director or designee will				
	check for work orde	ers prior to leaving for the day				
	to assure all items v in place to complete	were addressed or have plan				
	in place to complete	e uniciy				
		ary will be reviewed by the				
	NHA (nursing home Maintenance Direct	e administrator) and for to identify any outstanding				
		at are occurring within the				
	facility.					
	NJAC 8:39-4.1(a)1	1				
F 609	Reporting of Allegeo	d Violations	F 60	99		11/21/24
SS=D	CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)				
	§483.12(c) In respo	onse to allegations of abuse,				
	neglect, exploitation	n, or mistreatment, the facility				
	must:					

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES	I		FORM OMB NO	: 03/31/2025 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		315524	B. WING			/16/2024
	PROVIDER OR SUPPLIER	TION AND HEALTHCARE CENTE	ER	STREET ADDRESS, CITY, STATE, Z 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 609	§483.12(c)(1) Ensu involving abuse, ne mistreatment, inclu- source and misapp are reported immed hours after the alleg that cause the alleg serious bodily injury the events that cau abuse and do not re the administrator of officials (including t adult protective ser for jurisdiction in lor accordance with St procedures. §483.12(c)(4) Repo investigations to the designated represe accordance with St Survey Agency, with incident, and if the a appropriate correct This REQUIREMEN by: Based on interview other pertinent door that the facility faile of NJ EX Order 26.4 administrator and th Health (NJDOH). T identified for 1 of 3 reviewed for an alle This deficient pract following:	re that all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events pation involve abuse or result in λ , or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established of the results of all e administrator or his or her intative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced vs, record review and review of umentation, it was determined d to report timely an allegation (D)(1) to the facility ne New Jersey Department of his deficient practice was residents (Resident #173) egation of Descret ice was evidenced by the ar of the facility on 10/08/24 at	F 6	309 1. Resident #173 ^{NJ Ex} the facility. The facility reported the allegation to the Department of a contract the identifie facility ^{NJ Excession} . On 10/18/24, The Medic re-educated the identifie facility ^{NJ Excession} policy upor the investigation and prior work. LPN/UM #4 and the iden were re-educated abuse policy on 10/15/24	event of the nent of Health on al Director d ^{weff} on the n completion of or to returning to ntified ^{weff(x)(y)(y)} ed on the facility	

Facility ID: NJ03015

If continuation sheet Page 20 of 171

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2025 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		315524	B. WING	·		0 10/1	6/2024
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
		TEMENT OF DEFICIENCIES	ID	L	PROVIDER'S PLAN OF CORRECTION	N.	(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	I	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	Continued From pa	ge 20	F	609			
		#173 was observed seated on			Administrator to include clear and t	imely	
		I. When interviewed, the			communication to the facility and ti		
		at times as they described			reporting per regulatory guidelines.		
	how they were spol	ken to by the US FOA (D)			2. Current residents have the pote		
	. T	he resident stated that the			be affected. On 10/15/24, Social W	orkers	
	told them that NJ Ex O	rder 26.4(b)(1) if they did not take			interviewed all current residents that		
		e resident stated that he/she			visited by the NP were interviewed		
		Order 26.4(b)(1) . The resident ferred to take a more Net order 25.4			reviewed for abuse /neglect concer timely resolution and timely reportir		
		rder 26.4(b)(1) instead of taking			no further variances noted.	ig with	
	medication such as	NJ Ex Order 28.4(b)(1) The resident			Staff were interviewed for any know	vledge	
		l declined the medication and			of grievances or abuse/neglect with		
	that was what the	was mad about. The			further variances noted.		
	resident stated that	they were most upset about			3. The U.S. FOIA (b) (6) and ^{U.S. FOIA (t} we		
	the fact that the	took away his/her			re-educated on the facility abuse p		
	in their Max	resident feared getting ^{NExores}			include timely reporting by Regional Director of Clinical Services on 11/5		
		spoken with both the USTFOR(D)			Facility staff and external of		
		Exorder 28.4(b)(1) about the incident.			providers were re-educated by the	innear	
	,				Regional Director of Clinical		
		nt #173's Admission Record			Services/designee on the facility		
		mary) revealed that the			abuse/neglect policy to include time		
		ed to the facility with diagnosis			reporting requirements per regulate	ory	
	which included but	were not limited to; NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1)			guidelines. Staff re-education included those		
	NJ Ex Ord	ler 26.4(b)(1) , ^{NJ Ex Order 26.4(b)(1)}			identified in the 2567		
).			4. The Director of Social		
	NJ Ex Order 26.4(b	(1) · · · · · · · · · · · · · · · · · · ·			Services/Designee will interview 3		
), and			residents and audit 3 facility grieva		
	NJ Ex Order 26.4(b)(1)			weekly to validate potential concern		
					related to abuse/neglect were addr	essed	
					per facility policy to include timely reporting. Variances will be immed	liately	
					addressed. These audits will be	atory	
					conducted weekly x 4 weeks, then		
					monthly x 2 months. The findings of	of the	
		nt #173's quarterly Minimum			audits will be submitted by the		
		assessment tool, dated			Administrator to the QAPI Committ		
	revealed t	hat the resident's Brief			review and recommendation month	nly for 3	

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′			COMF	E SURVEY PLETED
		315524	B. WING			0 10/1	5 16/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	Continued From pa	ae 21	F 6				
	Interview for Mental out of 15, which ind NJ Ex Order 26.4(b)(I Status (BIMS) score was licated that the resident was 1). The remainder of the		00	months or ongoing until compliance sustained.) is	
	assessment remain	ned in progress. nt #173's Care Plan included					
	and/or potent NJ Ex Order 204(0)(1) NJ Ex Order will be free from s/s NJ Ex Order 204(0)(1) by/throu included: Administe Monitor for side effe Educate me/RP (re	with a Focus of: I have ware tial ware tial ware to the focus of the f					
	U.S. FOIA (b) (6) and/or significant ch resident's Care Plan the resident's refusa) of significant abnormalities hanges from baseline. The n failed to contain an entry for al of medications or n related interventions.					
	Record (EHR) revea Note dated ^{NECOMP73.40} "The reason for the NJ Ex Order 26.4(b),NJ Ex Order 26.4(b)(1)The					
	nursing request. Pu refusing ^{NEX Order 20.4(b)(1)} is currently on NJ Ex , and NJ E	at the resident was seen per ur [sic.] nursing the patient is supplementation. The patient Order 26.4(b)(1) ^{NU Ex Order 28.4(b)(1)} x Order 26.4(b)(1)). The ^{US.FC} the resident refused to talk to					
	this author. reports NEX Order 284(0)(1) or medic with patient risk for of NJ EX Order 264(0)(1) w patient placed NJ E	he/she does not wish to take cations, attempted to discuss NJEX Order 26.4(b)(1) if untreated, risk ith large amount of					

Facility ID: NJ03015

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CENTERS FOR MEDICARE & MEDICALD SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X) PROVIDER DESIDEPTIENCIAL DENTIFICATION NUMBER: (X) PROVIDER SUPPLIENCIAL 315524 (X) PROVIDER CONSUMPLIENCIAL 315524 (X) PROVIDER CONSUMPLIENCIAL 315724 (X) PROVIDER CON			AND HUMAN SERVICES				FORM	APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING C C C MALE OF PROVIDER OR SUPPLIER 315524 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE (PA) (EACH DEFICIENCY MISSI BE PRECEDED BY FULL REGULATORY OR LISC DENTIFICATION INFORMATION D PREFIX PROVIDER SPLAN OF CORRECTIVE ACTION SHOULD BE CROSS-RETERENCED TO THE APPROPRIATE DEFICIENCY OR LISC DENTIFICATION INFORMATION D F 609 Continued From page 22 noted								
31524 B. WING 10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STREE, ZIP CODE JAURE L BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STREE, ZIP CODE OPENING WIST EF PROCEEDED BY FULL TAG SUMMARY STATEMENT OF DEFICIENCIES PROVE ADDRESS FLAM OF CORRECTION (PACH OPROVED TA CITON HOULD BE CONSTRUCT ACTION HOULD BE CONSTRUCT				l` '				MPLETED
AUJREL BROOK REHABILITATION AND HEALTHCARE CENTER 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 PHETIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULTORY OR LSCIDENTFINIS MEDRACED BY FULL TAG D D PHETIX TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE DEFICIENCY COMPLETION DEFICIENCY COMPLETION DEFICIEN			315524	B. WING			10	
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER MOUNT LAUREL, NJ 08054 (MU)D PREEX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATIONY OR LSC DENTIFYING INFORMATION) D D D D D D D D D D D D D D D D D D D	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE,							
PREFX TXB (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TXB CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETION DEFICIENCY F 609 Continued From page 22 noted	LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER							
noted If Science (a) Oriented to Science (a) Science (a) Science (b) Science (c) Scienc	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFID	‹	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
him that he/she was wereard just wereard to the LPN/UM #4 stated that the nurses said the resident was wereard medications and we put the resident in to see wereard LPN/UM #4 stated that the resident did not bring it to his attention	F 609	noted ^{NJ Ex Order 28.4(b)(1)} Oriente N Ex Order 28 Oriented to N speaking to USIFE reg. nursing and will disc due to patient refus supplementation an patient at risk for NJ risk for NJ Ex Order 20 will allowRx (pres N Ex Order 28.4(b)(1) placed, for NJ Ex Order 26. the am only, continue daily ^{NJ Ex Order 26.} the am only, continue daily ^{NJ Ex Order 20.4(b)(1)} recalled speaking w resident would no N was called and he t N Ex Order 28.4(b)(1) The USIFE if there was a reaso N Ex Order 28.4(b)(1) The USIFE if there was a reaso N Ex Order 28.4(b)(1) The USIFE if there was a reaso N Ex Order 28.4(b)(1) The USIFE if there status ask to stay on USECORE During an interview at 1:18 PM, License Manager (LPN/UM) with Resident #173 him that he/she was LPN/UM #4 stated of resident was NSCORE?	Oriented to NEXCON EXCOMPTONIC IN EXCONPTONIC IN EXCONPTION IN EXCONPTION IN EXCONPTION IN EXCONPOLICIES INTERVIEWED INTERVIEWED IN EXCONPOLICIES IN EXCONPOLICIES IN EXCONPOLICIES INTERVIEWED INTERVIEWED IN EXCONPOLICIES IN EXCONPOLICULAR INTERV	F 6	09			

Facility ID: NJ03015

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES					0938-0391
	F CORRECTION	IDENTIFICATION NUMBER:	1 ° '				PLETED
						(0
		315524	B. WING	0.7		10/*	16/2024
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
I LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER			OUNT LAUREL, NJ 08054				
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
F 609	Continued From no	no 00	– 00				
F 009		ge 23 NJ ^{Ex Order 26.4(b)(1)} from the ^{U.S. FOV}	F 60	9			
		nterview with the surveyor on					
		M, the surveyor asked ported Resident #173's					
		by the US FOW The LPN/UM #4					
		nes the resident did not					
		nd wanted to do things the 4 further stated, "I am going to					
	report it."	Further stated, Fair going to					
	0- 40/45/04 -+ 0-4/						
		AM, the surveyor requested vestigations related to					
		the U.S. FOIA (b) (6)					
) confirmed that there were					
	none.						
		with the surveyor on 10/15/24					
		ted the allegation of Netoclered to					
		hen I was done talking to you					
	and he ordered the	U.S. FOIA (b) (6) to talk with the					
	· · · ·	e stated that no further ompleted on his end.					
	investigation was co	ompleted on his end.					
		Services note dated N Ex Order 26.4(b)(1					
		d that the second documented, sident and provided					
		and provided					
	NJ Ex Order 28.4(b)(1) referral	made for an added layer of					
	monitor and remain	ort. will continue to					
	During an interview	with the surveyor on 10/15/24					
		stated that LPN/UM #4 ny concerns to her regarding					
	Resident #173. The	reconfirmed that no					
	reportable events o	r investigations were					
	completed for the re	esident. The ^{U.S. FOIA (b) (6)}					

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DEPAR	FORM	APPROVED				
		& MEDICAID SERVICES			OMB NO. 0938-0391 (X3) DATE SURVEY	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	Сом	PLETED
		315524	B. WING			C 16/2024
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	. BROOK REHABILITA	TION AND HEALTHCARE CENTE	IR	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 609	U.S. FOIA (b) (6)), while ndNJ Ex Order 20 mentioned to the us want to follow the us came to me "The resident did no recommendations of because he/she has his/her life and did no The user of stated that then it would be rep At that time, the user she did not recall w speak with Residen that it was LPN/UM was not informed th prior to seeing the r the resident chose or recommendation The user stated the wanted to NJ Ex Or understood the pote following medication to do things on their party. At that time, the user should have reports should have followed Department of Heal	o was present, stated that (4(b)(1) was made, the """""""""""""""""""""""""""""""""""	F 60			

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES			0		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION			E SURVEY PLETED
							c
		315524	B. WING		_		- 16/2024
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STA	TE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENT	ER	3718 CHURCH ROAD			
				MOUNT LAUREL, NJ 08			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAI (EACH CORRECTIVE	N OF CORRECTION E ACTION SHOULD		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED) TO THE APPROPP CIENCY)	RIATE	DATE
			1				
F 609	Continued From pa	ae 25	F 609	9			
		3					
		t abuse, neglect, exploitation					
		of resident property are					
	strictly prohibited.						
		xpected to report any signs					
		buse/neglect to their					
	immediately.	director of nursing services					
		y policy, "Accidents and					
		ting and Reporting" dated evealed the following:					
		erealea ne renevning.					
		dents involving residents,					
		, vendors, etc., occurring on be investigated and reported					
	to the administrator						
							
		or/charge nurse and/or the r or supervisor shall promptly					
		ent investigation of the					
	accident or incident	t.					
	The nurse superv	/isor/charge nurse and/or the					
		r or supervisor shall complete					
	a Report of Inciden	t/Accident form and submit the					
	original to the direct 24 hours of the inci	tor of nursing services within					
		sing services shall ensure that					
		eceives a copy of the Report of for each occurrence					
	incluent/Accidents	ior each occurrence					
	NJAC 8:39-9.4(f)						
F 640		ting Resident Assessments	F 640	ו			11/21/24
SS=D	CFR(s): 483.20(f)(1	1)-(4)					
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: UBXH1	1 F	acility ID: NJ03015	If continuatio	n sheet P	age 26 of 171

		AND HUMAN SERVICES					FORM	APPROVED
			(X2) MULTI		NSTRUCTION	0	MB NO. 0938-0391 (X3) DATE SURVEY	
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN					PLETED
		045504						C
	PROVIDER OR SUPPLIER	315524	B. WING	STDEE	T ADDRESS, CITY, STATE,		10/1	16/2024
NAME OF F	ROVIDER OR SUPPLIER				HURCH ROAD			
LAUREL	BROOK REHABILITA	ATION AND HEALTHCARE CENTE	ER		IT LAUREL, NJ 08054	4		
(X4) ID			ID		PROVIDER'S PLAN OF			(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE AC CROSS-REFERENCED TO	THE APPROPF		COMPLETION DATE
					DEFICIEN	CY)		
F 640	Continued From pa	26 and	F 64					
1 040	§483.20(f) Automat	-	Г 04	0				
	requirement-							
		ding data. Within 7 days after						
		a resident's assessment, a e the following information for						
	each resident in the							
	(i) Admission asses							
	(ii) Annual assessm	nent updates. Ige in status assessments.						
	(iv) Quarterly review	•						
	(v) A subset of item	is upon a resident's transfer,						
	reentry, discharge,							
	is no admission as	ce-sheet) information, if there sessment.						
	C (00 00/6)/0) Trene							
		mitting data. Within 7 days bletes a resident's assessment,						
		apable of transmitting to the						
	CMS System inforn	nation for each resident						
		DS in a format that conforms to outs and data dictionaries,						
		andardized edits defined by						
	CMS and the State							
	8/183 20/f)(3) Trans	mittal requirements. Within						
		lity completes a resident's						
	assessment, a facil	lity must electronically transmit						
		and complete MDS data to						
	(i)Admission asses	ncluding the following: sment						
	(ii) Annual assessm	nent.						
		nge in status assessment.						
		ection of prior full assessment. ection of prior quarterly						
	assessment.	alon of phot quarterly						
	(vi) Quarterly review							
	(VII) A subset of iter reentry, discharge,	ns upon a resident's transfer, and death						
	reentry, discharge,							

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB						
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315524	B. WING _		C 10/16/2024		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD			
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION		
F 640	 (viii) Background (fainitial transmission of does not have an ad §483.20(f)(4) Data fa transmit data in the for a State which haby CMS, in the form approved by CMS. This REQUIREMENDY: Based on interview determined that the Tracking Record (D (MDS), an assessme management of car residents (Resident reviewed for resident reviewed for resident following: 1. On 10/11/24 at 1: completed record respecific to MDS assessme Resident #108 was res resident #108 was resident #108 was	ace-sheet) information, for an of MDS data on resident that dmission assessment. Format. The facility must format specified by CMS or, as an alternate RAI approved hat specified by the State and NT is not met as evidenced and record review, it was facility failed to complete a ischarge) Minimum Data Set thent tool used to facilitate the e of all residents, for 2 of 38 #108 and Resident #406) int assessments. In assessments. In assessments. In assessment. It discharged to facilitate the essment. It discharged to facilitate for a facility failed on PM, the surveyor eview of Resident #108 sessment. It discharged to facilitate for a facility failed for a facility failed for a facilitate for a facil	F 64	 Resident #108 NJ Ex Order 26.4(b)(the facility. The MDS Coordinator completed the discharge tracking re on 10/12/24 Resident #406 NJ Ex Order 26.4b1 at facility. The MDS Coordinator comp the discharge tracking record on 8/2 Residents who were discharged the facility have the potential to be affected. A review of residents who discharged for the last 30 days was completed to validate that the disch assessment/tracking record was completed timely per requirement. If further findings. The US FOIA (b)(6) was re-educated by the Regional Director Case Management on 10/31/24 on need to complete. encoding/transm resident assessments timely per regulatory requirement. Staff educa included those identified in the 2567 The Director of Nursing/Design review 3 residents discharged to va discharge/tracking assessments we completed timely per regulatory requirement. Variances will be immediately addressed. These aud 	ecord the pleted 2/24 d from were arge No or of the itting tion 7 ee will lidate ere		

Facility ID: NJ03015

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED C NAME OF PROVIDER OR SUPPLIER 315524 B. WING 10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054	DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938								
315524 B. WING 10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPRO	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY		
3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EA			315524	B. WING _					
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER 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) COMPLETION DATE F 640 Continued From page 28 was 101 days overdue. F 640 F 640 Resident #406 was discharged to Was completed on 101000000000000000000000000000000000	NAME OF	PROVIDER OR SUPPLIER							
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 640 Continued From page 28 was ¹¹⁰ days overdue. F 640 F 640 be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Director of Nursing to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained. Resident #406 was discharged to Was ¹¹⁰ days overdue. Image: Completed on Matter of the submitted by the Director of Nursing to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained.	LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R					
was was days overdue. be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Director of Nursing to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained. Resident #406 was discharged to was discharged to was overdue. Image: Commendation monthly for 3 months or ongoing until compliance is sustained. Resident #406 was discharged to was discharged to make and recommendation monthly for 3 months or ongoing until compliance is sustained. Resident #406 was discharged to make and recommendation monthly for 3 months or ongoing until compliance is sustained. Resident #406 was discharged to make and recommendation monthly for 3 months or ongoing until compliance is sustained.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	c	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION	
Resident #406 was discharged to Use Screated on Screated End of PPS Part A Stay MDS was completed on Use Screated End of PPS Part A Stay MDS was completed on Use Screated End of PPS Part A Stay MDS was Screated and Screated End of PPS Part A Stay MDS was Screated end Screated End of PPS Part A Stay MDS was Screated end Screated End of PPS Part A Stay MDS was Screated end Screated End of PPS Part A Stay MDS was Screated end Screated End of PPS Part A Stay MDS was Screated end Screated End of PPS Part A Stay MDS was Screated End of PPS Part A Stay MDS and Screated End of PPS Part A Stay MDS Masses Screated End of Screated End of Screated End of Screated End of PPS Part A Stay MDS Screated End of	F 640	was days overdu Resident #406 was was completed on was completed on was days overd Resident #406 was PPS Part A Stay MI The discharge MDS Resident #406 was PPS Part A Stay MI The discharge MDS On 10/15/24 at 10:3 interviewed the U.S the facility for almost stated, the 14th day, which on completing the M admissions and dis for those two reside were all completed On 10/15/24 at 12:2 provided the survey Reports from the Co Medicaid Services (revealed the Completed late. On 10/15/24 at 1:50 presence of the Fed	A. A	F 64		be conducted weekly x 4 weeks, th monthly x 2 months. The findings o audits will be submitted by the Dire Nursing to the QAPI Committee for and recommendation monthly for 3 months or ongoing until compliance	f the ctor of review		

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		315524	B. WING) 16/2024
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054			
<mark>(</mark> X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD	BE	(X5) COMPLETION DATE
F 640 F 645 SS=E	U.S. FOIA (b) (6)), U.S. FOIA (regarding the conce completion. The Use the problem has be issue." The surveyor staff that the CMS will late MDSs. A review of the mose Procedure titled "M Submission Timefra 2023 revealed, 'Tim submission of asse current requirement Assessment Instrum NJAC 8:39 - 11.1 PASARR Screening CFR(s): 483.20(k)(' §483.20(k) Preadmindividuals with a minimit with intellectual disa §483.20(k)(1) A num or after January 1, ' (i) Mental disorder a (i) of this section, un authority has determindependent physic performed by a period State mental health (A) That, because of condition of the indi), U.S. FOIA (b) (6)), U.S. FOIA (b) (6) (6)), U.S. FOIA (b) (6)), U.S. FOIA (b)	F 64				11/21/24

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/31/2025 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315524	B. WING _			C 16/2024
	PROVIDER OR SUPPLIER	TION AND HEALTHCARE CENTE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
<mark>(</mark> X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 645	and (B) If the individual services, whether the specialized services (ii) Intellectual disability authority has deterred (A) That, because of condition of the individual services, whether the specialized services §483.20(k)(2) Excer section- (i) The preadmission paragraph(k)(1) of the for determinations into to a nursing facility being admitted to the transferred for careed (ii) The State may of preadmission screed paragraph (k)(1) of to a nursing facility (A) Who is admitted hospital after received hospital, (B) Who requires me condition for which the hospital, and (C) Whose attending before admission to services attending services attending to a difference attending the services att	requires such level of the individual requires s; or polity, as defined in paragraph ion, unless the State y or developmental disability nined prior to admission- of the physical and mental vidual, the individual requires s provided by a nursing facility; requires such level of the individual requires s for intellectual disability. ptions. For purposes of this this section need not provide in the case of the readmission of an individual who, after the nursing facility, was in a hospital. thoose not to apply the ening program under this section to the admission	F 64	5		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE SURVEY COMPLETED		
		315524	B. WING		C 10/1) 6/2024	
NAME OF	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	RI	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 645	Continued From pa	ge 31	F 645	5			
	§483.20(k)(3) Definisection- (i) An individual is c disorder if the individual is c disorder defined in 4 (ii) An individual is c intellectual disability intellectual disability or is a person with a described in 435.10 This REQUIREMEN by: Based on interview of pertinent facility of determined that the complete a Preadm Resident Review (F resident was referre state-designated au evaluation and deter practice was identifi (Resident #97) revie was evidenced by the On 10/15/24 at 10:0 the electronic media A review of the Adm admission summar had diagnosis that in NEX OTHER 264(0)(1) and in A review of the PAS dated NERCOTHER and signal Section II - NEX OTHER and signal	ition. For purposes of this onsidered to have a mental dual has a serious mental 483.102(b)(1). considered to have an v if the individual has an v as defined in §483.102(b)(3) a related condition as 10 of this chapter. NT is not met as evidenced vs, record review, and review documentation it was facility failed to accurately ission Screening and VASARR) to ensure the ed to the appropriate athority for level II PASARR ermination. This deficient ied for one (1) of 1 resident ewed for level II PASARR and he following: 08 AM, the surveyor reviewed cal record for Resident #97. hission Record face sheet (an y) reflected that the resident ncluded, NJ Ex Order 26.4(b)(1),		 Resident #97 was reviewed by Director of Social Services with related to cited occu Resident #97 PASARR level one ar are completed and accurate as 10/ The U.S. FOIA (b) (6) was re-educated on the PASARR and th need to validate timely completion. Current residents have the pote be affected. Resident PASARR was reviewed for accuracy and validatio those who required a level two PAS had one completed on 11/11/24. No further findings. The Director of Social Services re-educated US FOIA (b)(6) on the PASARR regulatory requirement to include need for accuracy and time completion of level two as indicated 4. The Director of Social Services audit 3 residents that are new / readmissions to validate PASARR accuracy and validate that level two PASARR timely completion as indic Variances will be addressed. These will be conducted weekly x 4 weeks 	rrence. nd two 10/24. s ne ential to s n that ARR b ly l. will sated. a audits		

Facility ID: NJ03015

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		AND HUMAN SERVICES	_			FORM	03/31/2025 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		315524	B. WING				16/2024	
NAME OF F	PROVIDER OR SUPPLIER	l	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL	BROOK REHABILITA	ATION AND HEALTHCARE CENT	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 645	Continued From pa	ige 32	F 6	45				
	level II PASARR to Step 2: Determine I Outcome revealed refer to NJ EX Orde Section VIII - PASR and Certification of Completing Level I screen: admit to NJ A review of the Not Preadmission Scre (PASARR) Evaluati by the reflected level II PASARR ev placement in a Med Further review of the evidence of a level On 10/15/24 at 10:: interviewed the regarding the PASA admission the PASA electronic medical in kept a spreadsheet) screening, which required a be completed. Final Level I Screening a ^{NECORFECTION} screening and to r 26.4(b)(1) RR level Screening Outcome Screening Professional form revealed a ^{NECORFECTION}			monthly x 2 months. The findings audits will be submitted by the D Social Services to the QAPI Com for review and recommendation for 3 months or ongoing until cor is sustained.	rector of mittee monthly		
	reviewed the PASS every year, and the EMR. The USE FOLKIO from NJ EXOTOR 26.4(b)(1) ar	ARs, updated the PASSAR's in uploaded them into the plained if the resident came ind was in NJ Ex Order 26.4(b)(1) and I and level II it would be a part						

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		AND HUMAN SERVICES		P		APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			MB NO. 0938-0391	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	COM	E SURVEY PLETED
		315524	B. WING			C 16/2024
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	. BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 645	of the admission re the resident was in review the level I ar update the PASARI about Resident #97 notification for refer evaluation complete the second in the second review it and the second review it and the second referral for level II. On 10/15/24 at 11:0 level I PASARR and to reflect a second into it. During an interview at 11:17 AM, the application will not it 10/17/24 by the second regional second be c she would have to g regional second to see completed. The stated that the level EMR "was uploade modified and the second accurate of the second for the clarification of	ge 33 cords. She further explained if long term care she would a level II and they would R every year. When asked "s figure on the stated by the figure on the stated they would need to hey could provide the stated they would need to hey could provide the level I and notice of 00 AM, the figure provided the d stated that it was corrected level I. When asked about the cation for the level II and was I, the figure stated she would with the surveyor on 10/15/24 figure stated "the full level II be completed until Thursday FOA(0)(6) and then it would be tited that day. When asked completed? The figure stated get the answer from the when the level II should be figure confirmed the resident had reening and a level II should ded prior to surveyor inquiry. 20 AM, the figure provided ARR. At that time, the figure I that was originally in the d by error" and that it was econd copy she provided was figure passant it was for a level I was	F 64			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315524	B. WING _				C 16/2024
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		18 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 645	Clarifications" on the Clarifications" on the On 10/15/24 at 11:3 third copy of the level stated that she PASARR in the EM have to speak to the PASARR in the EM have to speak to the Second Second Second Second the level I and after for level II when the During a follow up in 10/15/24 at 12:01 P notification of referr state would review is She was unable to follow up if there was completion of the let the resident would P and acknowledged completed prior to second On 10/15/24 at 4:51 presence of the U.S. On 10/15/24 at 4:51 presence of the U.S. (U.S. FOIA) , the U.S. F) , U.S. FOIA (team the expectation be completed prior Completed prior Completed prior	stated that she "would get e PASARR. 00 AM, the """ provided a rel I PASARR. At that time, the just modified the level I R. She stated that she would e supervisor to see when the should have been reflected on the notification of the referral elevel II should be completed. Interview with the """" on M, the """" stated once the al was submitted then the it and complete the level II. speak on when they should as no response for the evel II. The """"" emphasized have the level II completed it should have been surveyor inquiry. I PM, the U.S. FOIA (b) (6) (b) (6) OIA (b) (6) (c) (6) (c) (6) (c) (6) (c) (6) (c) (6) (c) (6) (c) (6) (c)	F 64	45			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/31/2025 APPROVED 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	CORRECTION	IDENTIFICATION NOWDER.	A. BUILDIN	G		
		315524	B. WING			16/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) Completion Date
F 645 F 656	he or she is referred representative for th determination) scre PASARR represent report to the facility. NJAC 8:39-11.2(i), 2	d to the state PASARR ne level II (evaluation and ening process. 8d. The state ative provides a copy of the "	F 64 F 65			11/21/24
	CFR(s): 483.21(b)(§483.21(b) Compre §483.21(b)(1) The f implement a compr care plan for each r resident rights set fo §483.10(c)(3), that objectives and time medical, nursing, ar needs that are ident assessment. The co describe the followin (i) The services that or maintain the resid physical, mental, ar required under §483. (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclu- treatment under §443. (iii) Any specialized rehabilitative service provide as a result of recommendations. findings of the PAS, rationale in the resident	1)(3) hensive Care Plans acility must develop and ehensive person-centered esident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's nd mental and psychosocial tified in the comprehensive omprehensive care plan must ng - t are to be furnished to attain dent's highest practicable ind psychosocial well-being as 3.24, §483.25 or §483.40; and t would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 33.10(c)(6). services or specialized es the nursing facility will				11/21/24

Facility ID: NJ03015

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′			Сом	E SURVEY PLETED
		315524	B. WING	;			_ 16/2024
NAME OF F	PROVIDER OR SUPPLIER			I .	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENT	ER	I .	718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 656	desired outcomes. (B) The resident's p future discharge. Fa whether the resider community was ass local contact agence entities, for this pur (C) Discharge plans plan, as appropriate requirements set for section. §483.21(b)(3) The side of the section of the section. §483.21(b)(3) The side of the section of the section of the section. Solution of the section of the section of the section of the section of the section. Section of the section of the sectio	tative(s)- goals for admission and preference and potential for acilities must document of's desire to return to the sessed and any referrals to dies and/or other appropriate pose. Is in the comprehensive care e, in accordance with the orth in paragraph (c) of this services provided or arranged utilined by the comprehensive mpetent and trauma-informed. NT is not met as evidenced tion, interview, record review, nent facility documents, it was lity failed to develop and rehensive person-centered ded measurable objectives, ventions to meet resident's s specifically by failing to lan for a resident diagnosed hission. The deficient practice of 6 residents (Resident #167) essary medication. ice was evidenced by the B1 AM, during the initial tour, ved Resident #167 in their		656	 Resident#167 NJ Ex Order 26.4 facility Current residents have the be affected. On 11/1/24, Unit M completed an audit of residents diagnosis of anxiety was comple validate an individualized care p place. No further findings. The licensed nurses were re-educated by Director of Nurs 10/31/24, on developing and implementing comprehensive person-centered care plans tha measurable objectives, timeline interventions to meet resident's psychological needs to include implementing care plans for residiagnosed with anxiety. Staff re included those identified in the 2 	potential to anagers with a eted to blan is in ing, t included s, and idents -education 2567.	
	A review of Resider	nt 167's Admission Record			4. The DON/designee will aud	it 3 lation sheet P	

Facility ID: NJ03015

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315524	B. WING				C 16/2024
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	. BROOK REHABILITA	TION AND HEALTHCARE CENT	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 656	face sheet (an adm that they had a diag limited to; U.S. FOI , and U.S. A review of the corr Set (MDS), an asse under Section I- rev Networkster A review of the phy the following: NJ EX) oral ta one (1) tablet by man needed for Networkster A review of the Ind Care Plan (ICCP) of and interventions th #167 had Networkster During an interview at 12:28 PM, the U stated that if a resid and was being treat be on the resident's A review of the facil Comprehensive Per March 2022, reveat person-centered car measurable objectit describes the servit attain or maintain the	ission summary) revealed gnosis that included but not A (b) (6)	F 6		residents that are new admissions newly diagnosed with anxiety to va- care plan is in place and implement Variances will be addressed. Thes will be conducted weekly x 4 week monthly x 2 months. The findings of audits will be submitted by the Dire Nursing to the QAPI Committee for and recommendation monthly for 3 months or ongoing until compliance sustained.	lidate a tted. e audits s, then of the ector of r review e is	ane 38 of 171

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′			Сом	E SURVEY PLETED
		315524	B. WING	;			C 16/2024
NAME OF	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILIT	TION AND HEALTHCARE CENTI	ER	I	718 CHURCH ROAD NOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 657	Continued From pa	ge 38	F	657			
F 657 SS=E	Care Plan Timing a CFR(s): 483.21(b)(F	657			11/21/24
	 §483.21(b)(2) A conbe- (i) Developed within the comprehensive (ii) Prepared by an includes but is not I (A) The attending p (B) A registered nurresident. (C) A nurse aide wiresident. (D) A member of for (E) To the extent prother resident and the resident and the resident and the resident for the resident and their resident resident for the resident's care plar (F) Other appropriate disciplines as deternor as requested by (iii)Reviewed and reteam after each as comprehensive and assessments. This REQUIREMED by: Based on observation and review of pertindetermined that the resident's individua (ICCP) related to a set of the resident of the resident's individuation of the resident of the resident of the resident's individuation of the resident's individuation of the resident of the resident of the resident of the resident's individuation of the resident's individuation of the resident of the resident's individuation of the resident of the resident's individuation of the resident of t	interdisciplinary team, that imited to ihysician. rse with responsibility for the th responsibility for the od and nutrition services staff. racticable, the participation of e resident's representative(s). Is the included in a resident's e participation of the resident epresentative is determined the development of the n. the staff or professionals in mined by the resident's needs the resident. evised by the interdisciplinary sessment, including both the			1. Resident #102 was re-evaluate 1. Resident #102 was reviewed and	1/24, to a ent to ident	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		FORM	03/31/2025 APPROVED
		MB NO. 0938-0391 (X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMF	PLETED
315524 B. WING		C 10/1	; 6/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
3718 CHURCH ROAD			
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER MOUNT LAUREL, NJ 08054			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COR	RECTION		(X5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COR PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION 1 TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD	BE	COMPLETION DATE
F 657 Continued From page 39 F 657			
per evaluation and individual			
This deficient practice was evidenced by the Resident #198 NJ Ex Order 26	.4b1 at	the	
following: facility.			
Resident #73 was re-evaluat		104 40	
1.) On 10/9/24 at 1:52 PM, the surveyor observed Resident #102, Nexocer and Nexocer sitting in a chair include but not limited to nee	n 10/1	/24, 10	
at a table in the outside smoking patio. The		ent to	
surveyor observed a NJ Ex Order 26.4(b)(1) with a safely store N ex order 26.4(b)	als. Res	sident	
NJ Ex Order 28.4(b)(1) on top of the NJ Ex Order 26.4(b)(1) on #73 care plan was reviewed			
the patio table. The resident confirmed the per evaluation and individual			
NU Ex Order 26.4(b)(1) and NU Ex Order 26.4(b)(1) and NU Ex Order 26.4(b)(1)		Order 26.4(b)(1	
he/she did not use a ^{NJ Ex Order 26.4(b)(1)} anymore. materials to be stored by nur			
Resident #102 further stated that he/she can 2. Current residents have t			
NJ Ex Order 26.4(b)(1) anytime between 8:00 AM be affected by cited practice.			
and 8:00 PM, and there was no supervision by the staff. Resident #102 stated that they kept their who smoke were re-evaluate nurse 10/11/24, with care pla			
Nexone stall. Resident #102 stated that they kept their for inconsistencies and revis			
evaluation and individualized			
A review of the Admission Record face sheet (an 3. The licensed nurses wer			
admission summary) reflected that Resident #102 re-educated by Director of			
was admitted to the facility with diagnoses which Nursing/Designee on 10/31/2	24 as it		
included, but were not limited to, NJ Ex Order 28.4(b)(1) relates to care plan timing an		ions to	
include revision of a resident			
, individualized comprehensiv			
NJ Ex Order 26.4(b)(1) (ICCP) related to smoking an accurate interventions are in			
are not conflicting based on			
A review of the annual comprehensive Minimum each resident. Staff education			
Data Set (MDS), an assessment tool used to those identified in the 2567		ucu	
facilitate resident care, dated Nexoner28400 , revealed 4. The Director of Nursing/	designe	e will	
a Brief Interview for Mental Status score of we out audit 3 residents that are sm			
of 15, which indicated the resident's cognition validate care plan accuracy be			
was Wexoner and currently NJ Ex Order 26.4(b)(1). resident evaluation and need			
will be addressed. These au		be	
A review of the Network Safety Evaluation, dated conducted weekly x 4 weeks		5 4h a	
Mexoneres, revealed that Resident #102 was able to monthly x 2 months. The find			
safely secure all secure and safely secure all secure and safely secure all s			
The interventions included: I will adhere to the and recommendation month			

Facility ID: NJ03015

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	FORM	03/31/2025 APPROVED					
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE		0MB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG_			PLETED
		315524	B. WING				C 16/2024
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		18 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	ID PREFIX				(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
F 657	Continued From pa	ae 40	F 65	57			
	facility NJ Ex Order 26.4(b)() poli	cy through the review date,			months or ongoing until compliance	e is	
	that for my safety th	ne facility will store my			sustained.		
	my ^{NJEXONGET26} and ^{NJEX Orde}	and the facility will store and the facility will store for safety reasons. The					
	interventions did no was needed.	t include a ^{NJ Ex Order 26.4(b)(1)}					
		nt #102's ICCP, with revision Ided a focus area of "I					
	that for	my safety, the facility will store					
	that the facility will s	to be a low to be					
	for safety reasons,	am able to Nex order 254 safely					
	NJ Ex Order 26.4(b)(1) (init	ated ^{WEX order 26.4(b)(1}), and I use a liated ^{WEX order 26.4(b)(1}).					
	2) On 10/9/24 at 1:	35 PM, the surveyor observed					
		Order 26.4(b)(1) in the N Ex Order 26.4(b)(
	area.						
		PM, the surveyor observed					
		rn to his/her room. At that tated he/she had been					
	NJ Ex Order 25.4(b) since adm	ission to the facility and kept					
		n his/her bedside drawer. ved three boxes of ^{NJExorder 26.4(0)(1)}					
		he resident's chair and the					
		her pocket when the surveyor					
	asked where he/she						
		t recent admission Minimum assessment tool, dated					
	NJ Ex Order 26.40, included th	e resident had a Brief					
	Interview for Menta	Status score of sout of 15,					
	WHICH INDICALED INE	resident's cognition was					

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DEPART	FORM	03/31/2025 APPROVED					
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT				0938-0391
	F CORRECTION	IDENTIFICATION NUMBER:	· · ·				PLETED
		315524	B. WING _				C 16/2024
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		18 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)		DATE
F 657	Continued From pa	ge 41	F 65	57			
		dent's NUEX OTHER 25.4(b)(1) Safety					
	Evaluation, dated	nflicting interventions that the					
	resident was to "sto	ore all NIEXOTOR 254(0) materials in my					
	room," and that, "th	e facility will safely secure all					
		dent's ICCP included a focus, "I with two conflicting					
	interventions: "store	e all ^{NJ Ex Order 25.4(b)(} materials in my					
	room," and that, "th	e facility will safely secure all					
		with the surveyor on 10/15/24					
		ed Nursing Assistant (CNA) #2 de aware of the Mexore 254(0)(
	her assignment thro	ough verbal report. The CNA					
		esidents should not have in their rooms and that					
		were locked up by the nurse.					
		with the surveyor on 10/15/24					
		sed Practical Nurse (LPN) #4					
	determined if a resi	dent was allowed to keep					
		in their room. The LPN further s were responsible for					
	reviewing and revis	ing the resident care plans so					
	that all staff would k status.	know the resident's current					
		with the surveyor on 10/15/24					
	at 12:26 PM, the U.	5. FOIA (b) (6) t residents who smoke were					
	assessed upon adn	nission to determine whether					
	materials or if	nold onto their own ^{Mexorder26400} *** ⁴⁰¹¹ materials would be kept					
	by the facility. The	further stated that the					
	nurses were respor	nsible for reviewing and					

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		AND HUMAN SERVICES				FORM	APPROVED
							. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY
		315524	B. WING				C
NAME OF F	PROVIDER OR SUPPLIER	313324		S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	16/2024
	NOVIDER OR SOFFEIER				718 CHURCH ROAD		
LAUREL	BROOK REHABILITA	ATION AND HEALTHCARE CENTE	ER	MOUNT LAUREL, NJ 08054			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
1/10					DEFICIENCY)		
		40					
F 657		-	F 6	57			
		nt care plans to reflect the nation about the resident.					
		Resident #198, the US FOIA (b) (b)					
	stated that the resid	dent kept his/her own ^{NJ Ex order 25.4(b)}					
	materials in his/her	room. At that time, the					
		the resident's ICCP with the how someone reading the					
	ICCP would know v	where the resident's NEX OTHER 25.4(0)					
	materials should be	e kept. The ^{u.s. Fola (b) (6)} stated,					
		Care Plan would have to be					
		further stated it was tely document where the					
		materials should be kept "to					
	make sure the resid	dents are safe."					
	3) On 10/9/24 at 11	1:31 AM, the surveyor					
		#73 lying in bed, resting with					
	their eyes closed.						
		sission Descend wells stad that					
		nission Record reflected that agnoses that included,					
		26.4(b)(1), and ^{NJ Ex Order 26.4(b)(1)} .					
		st recent quarterly Minimum					
		n assessment tool, dated ne resident had a Brief					
		I Status score of ∎ out of 15,					
		IJ Ex Order 26.4(b)(1)					
	A review of the real	dont's NJEXOTER254000 Cofot					
	A review of the residence of the residen	dent's ^{NEX ONE 2640(1} Safety EX OTHER 2641, included, the resident					
	smoked, and two co	onflicting interventions that the					
		pre all ^{NUEX order 25.4(b)(} materials in my					
	room," and that, "th	e facility will safely secure all					
	materials.						
		dent's ICCP included a focus,					
		with two conflicting					
	interventions: "I am	able to WEXOTORIZET independently					

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		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT				0938-0391
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN				PLETED
				-		(c l
		315524	B. WING	_		10/1	16/2024
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	IR		'18 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 657	and store all second at that, "for my safety, all second at that, "for my safety, all states and general unch. LPN #8 states kept in the medication of the medication of the medication of the surveyor the MJ EXO where the Metoder was not sure who kept in the medication of the METODER and general CNA #9 stated the net the Metoder and general CNA #9 stated the net the Metoder and general CNA #9 stated the further need an Metoder to the court surveyor and that resident to the court state to the further need an Metoder to the medication cart. During a follow up i 10/15/24 at 2:17 PM responsible for corr that it was done. She could do it, but it wa #2 stated the care p and as needed. She	Twith the surveyor on 10/9/24 #8 stated that she worked per report that the resident was a ally went [JEXORDE264(0)(1)] after ed that the [JEXORDE264(0)(1)] was ion cart. At that time, she cation cart and showed the rder264(0)(1). When asked as kept, LPN #8 stated she ept the [JEXORDE264(0)(1)] was ion cart and showed the rder264(0)(1). When asked as kept, LPN #8 stated she ept the [JEXORDE264(0)(1)] and the surveyor on 10/9/24 #9 stated the resident was a ally [JEXORDE264(0)(1)] and the aide went out with the tyard when he/she wanted to stated the resident did not of were just supervised. Twith the surveyor on 10/9/24 censed Practical Nurse/Unit #2) stated the resident was a 2 further stated that the surveyor on 10/9/24 censed Practical Nurse/Unit #2) stated the resident was a 2 further stated that the surveyor on A, LPN/UM #2 stated she was pleting the ICCP to ensure the further stated that anyone as her responsibility. LPN/UM olan was updated quarterly e explained the care plan was	F 65	57			
	10/15/24 at 2:17 PM responsible for com that it was done. Sh could do it, but it wa #2 stated the care p and as needed. Sho	M, LPN/UM #2 stated she was apleting the ICCP to ensure the further stated that anyone as her responsibility. LPN/UM blan was updated quarterly					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	TIPLE	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _			
		315524	B. WING				
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 657	which was done qui would be updated of stated that if things ICCP, she would try On 10/15/24 at 2:20 the ICCP in the elec and stated that the unit at that time the stated because the care unit which had wanted the Missource on the medication of she updated the ICC were stored at the r Further review of the revised on Missource and LPN/UM am able to Missource wat 4:20 PM, in the p the U.S. FOIA (b) (6 smoking care plan responses on the that any conflicting been corrected the management. A review of the facill Comprehensive Per 03/2022, included, ongoing and care p	arterly and anything new on the ICCP. LPN/UM #2 were contradicting on the y to review it and resolve it. DPM, LPN/UM #2 reviewed ctronic medical record (EMR) resident was not on the west ICCP was created. She resident was on the memory wandering residents, she was and the Matter to be stored eart. She further stated that CP to include that all items hurse's station. In ICCP, reflected it was by the U.S. FOIA (b) (6) A #2 to include intervention "I with supervision, and store all at the nurse's station" after n 10/9/24. With the surveyor on 10/15/24 were of the survey team, b) the U.S. Folk that the was auto populated by the Constant Safety Evaluation and interventions should have next day by nursing ity's "Care Plans, rson-Centered" policy, revised "Assessments of residents are lans are revised as ne residents and the residents'	F 65	57			

Facility ID: NJ03015

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APP CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093							
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	TE SURVEY MPLETED	
		315524	B. WING			C 10/16/2024	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8718 CHURCH ROAD			
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R I	MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 657	Continued From pa	ge 45	F 657				
	NJAC 8:39-27.1(a) Services Provided N CFR(s): 483.21(b)(3	Meet Professional Standards 3)(i)	F 658			11/21/24	
	The services provid as outlined by the c must- (i) Meet professiona This REQUIREMEN by: Complaint #: NJ170 Based on interview, pertinent facility doo that the facility failed assessed by a Regin NJ Ex Order 26.4(b)(1) and by a U.S. FOIA (b) (1) This deficient practic residents (Resident and evidenced by the Reference: New Jet 45. Chapter 11. Nur Practice Act for the "The practice of nur professional nurse in treating human resp	record review, and review of cuments, it was determined d to ensure a.) a resident was istered Nurse (RN) after d b.) a resident was evaluated as per a physician's order. ce was evidenced for 1 of 6 #305) reviewed for ^{NECORDEREMOND}		 Resident #305<mark>NJ EX Order 26.4(b)(</mark> the facility. Current residents at risk for fall the potential to be affected by this deficient practice. A review of curre residents with actual falls within the 30 days was completed by the Dire Nursing/Designee on 11/6/24 to val the resident was assessed timely b RN and that a physical therapy eva was completed if ordered by the clin provider. Variances were addressed 3. The licensed nurses were re-educated by Director of Nursing/Designee on 11/6/24 to inc residents being immediately assess a Registered Nurse (RN) with resul documented after sustaining a fall a following through to ensure that th physical therapy evaluation was 	s have nt last ctor of idate y an luation nical d. lude sed by ts and		
	such services as ca health counseling, a supportive to or resi and executing medi	ase finding, health teaching, and provision of care torative of life and wellbeing, ical regimens as prescribed by vise legally authorized		 completed if ordered by the clinical provider . Staff education included identified in the 2567. 4. The DON/designee will audit 3 residents post fall to validate that residents were timely assessed by a sessed by a s	those		

Facility ID: NJ03015

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APP CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093										
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY					
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		PLETED				
		315524	B. WING		0 10/1	; 6/2024				
NAME OF F	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE						
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	IR	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE				
F 658	Reference: New Jer 45, Chapter 11. Nur Practice Act for the "The practice of nur nurse is defined as responsibilities with finding; reinforcing for program through he counseling and prov- restorative care, un registered nurse or authorized physician A review of the Adm summary) reflected to the facility with di not limited to; Mercore Summary) reflected to the facility with di not limited to; Mercore (MDS), an assessm revealed that Reside for Mental Status (E indicated the reside . Further m Section NJ Ex Order NJ Ex Order 26.4(b) A review of the indiv plan (ICCP), initiate focus area of "I am NJ Ex Order 26.4(b)(1), N Interventions includ environment."	rsey Statutes Annotated, Title rsing Board. The Nurse State of New Jersey states: rsing as a licensed practical performing tasks and in the framework of case the patient and family teaching ealth teaching, health vision of supportive and der the direction of a licensed or otherwise legally n or dentist." hission Record (an admission Resident #305 was admitted agnoses which included, but with N Ex Order 26.4(b)(1) and and N Ex Order 26.4(b)(1) and mt #305 had a Brief Interview BIMS) of fill out of 15, which ent #305 had a Brief Interview BIMS) of fill out of 15, which eview of the MDS included in r 26.4(b)(1) and Goals that d N Ex Order 26.4(b)(1) with)(1)).	F 65		icated essed. ekly x 4 he ted by nths or					
	environment." A review of the facil	ty's Full QA (quality								

Facility ID: NJ03015

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		AND HUMAN SERVICES				FOR	D: 03/31/2025 MAPPROVED
		& MEDICAID SERVICES					D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		ATE SURVEY
		315524	B. WING _			1	C 0/ 16/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	:	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
F 658	Continued From pa	ge 47	F 65	58			
		revealed, on NJ Ex Order 26.4(0) at 10:00					
	AM, Resident #305	NJ Ex Order 26.4(b)(1) during a					
		ed to the wheelchair. CNA #13					
	[he/she] got in the c	chair, the cushion [he/she] has					
	on the chair slide m	haking [him/her]					
	assisted as [he/she	NJ EX Older 26.4(D)(1)					
		ence that a Registered Nurse					
		sident #305 after Nexonerate on					
	NJ EX Order 20.4(0), 1						
	A review of the U.S. note. dated NUEX Order 25.4(b)	FOIA (b) (6)) progress at 6:32 PM, revealed, the					
	us re assessed the re	esident and recommneded a Corder 26.4(b)(1)) for ^{NEX ONEE}					
		ence that Resident #305 was recommended by the					
	During an interview at 11:09 AM, the U.	with the surveyor on 10/15/24 S. FOIA (b) (6)					
		confirmed that the New					
	evaluation was not have been done as	done. When asked if it should					
	recommendation, s						
		with the surveyor on 10/15/24					
	at 12:26 PM, the U.	S. FOIA (b) (6) ocess was after a PO was					
		uld be notified that the resident					
		with the surveyor on 10/16/24					
		onducted after Mattered on					
1	1						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES ON								
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		315524	B. WING			C 16/2024		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R I	718 CHURCH ROAD				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) Completion Date		
F 658 F 684 SS=D	director of nursing s assesses all resider findings in the medi director or attending verify conclusions a medical or other sin NJAC 8:39-27.1(a) Quality of Care	-	F 658 F 684			11/21/24		
	applies to all treatm facility residents. Ba assessment of a re- that residents receive accordance with pro- practice, the compre- care plan, and the r This REQUIREMEN by: Complaint #: NJ17 Based on interview, of other pertinent do determined that the the appropriate care in treatment for a.) a in condition, with N	fundamental principle that ent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of ehensive person-centered esidents' choices. NT is not met as evidenced		 Resident #255 NJEX ORDER 204(b)(J) side the facility. Resident #7 clinical provider was mand the statement of the resident #7 clinical provider orders were review implemented per plan of care Current residents with orders for ultrasounds and / or CT scans have potential to be affected. An audit of current residents with orders for ST venous dopplers and CT scans in t 90 days were reviewed to validate completion and / or clinical provider 	otified #7 /ed and or e the TAT he last			

Facility ID: NJ03015

If continuation sheet Page 49 of 171

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X) DROWDERSUPPLIER (X) DROWDERSUPPLIER (X) DROWDERSUPPLIER STREET ADDRESS, CITY, STATE, AP CODE C AURC OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, AP CODE STREET ADDRESS, CITY, STATE, AP CODE C C CMUCHAEL BROOK REHABLITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, AP CODE STREET ADDRESS, CITY, STATE, AP CODE C CMUCHAEL BROOK REHABLITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, AP CODE STREET ADDRESS, CITY, STATE, AP CODE C LAUREL BROOK REHABLITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, AP CODE STREET ADDRESS, CITY, STATE, AP CODE C CALL STREET ADDRESS, CITY, STATE, AP CODE STREET ADDRESS, CITY, STATE, AP CODE C TAG REGULATORY OR ISC DENTFYING WROMMICON PROVIDERS PLAN OF CORRECTIVE AND STREEMORENTY C TAG REAL STREEMORENTY OF DEFICIENCY MISSING PROVIDER CONSTRUCTION AND AND AND AND AND AND AND AND AND AN			AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
315524 B. WING 1016/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, GITY, STATE, ZIP CODE STREET ADDRESS, GITY, STATE, ZIP CODRESCODE STREET	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS (CTY, STRE, ZIP CODE LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS (CTY, STRE, ZIP CODE (PAUP) SUMMARY STATEMENT OF DEFICENCIES The CAURCH NOD (PARTIN) (EACH DEFICIENCY) PREVIX (EACH DEFICIENCY MUST ER PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREVIX PREVIX (EACH DEFICIENCY) (EACH DEFICIENCY) PREVIX (CASS.REFERENCY) (EACH DEFICIENCY) Image and image			315524	B. WING				-
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER MOUNT LAUREL, NJ 08054 (pt] ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDE BY FULL RECULATIONY OR LSC DENTIFYING INFORMATION) ID DEFICIENCY TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY COMENT CACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY COMENT CACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY F 684 Continued From page 49 experienced Within a cocordance with professional standards of nursing practice. F 684 This deficient practice was identified for 1 of 1 resident (Resident #255) reviewed for a change in condition and 1 of 5 residents (Resident #7) reviewed for Watting 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 registered professional nurse is defined as diagnosing and treating human responses to actual and potential physician or dentist." F 684 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 cliensed provider or ders for diagnostic testing. Staff reseducation with no delay in treadment to include but not limited to nursing and envoits on for supportive to or restorative of life and wellbeing, and executing medical regimes as presoribed by a licensed or otherwise legally authorized physician or dentist." No P outpatient to include documentation in the 2677 The DON/Geignee will audit 3 resident with in delay in treadment to include but not limited to notifying the clinical provide	NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
WILD SUMMARY STATEMENT OF DEFICIENCES (EACH OFFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTVE ACTION SHOLD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET (EACH CORRECTVE ACTION SHOLD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) F 684 Continued From page 49 experienced (MISTATE) and UTCOLLESION was rescheduled for an outpatient (MISTATE ON SHOLD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) F 684 F 7684 F 684 RP notification with barriers or delays for further guidance. No further findings found. F 684 The ideficient practice was identified for 1 of 1 resident (Resident #255) reviewed for a change in condition and 1 of 5 residents (Resident #77) reviewed for MISTATE F 684 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 Tinding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of suportive and					37	718 CHURCH ROAD		
PRÉTIX TAG CEAH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉTIX TAG CEAH CORRECTIVE ACTION SHOULD BE CROSS-REGRECTIVE ACTION SHOULD BE CROSS-REGRECTIVE ACTION SHOULD BE DEFICIENCY COMPLET DEFICIENCY F 684 Continued From page 49 experienced difference interview and record ance with professional standards of nursing practice. F 684 RP notification with barriers or delays for further guidance. No further findings found. Continued From page 49 experienced difference interview and row of the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentst." F 684 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 finding; reinforcing the patient and family teaching program through health teaching, health conservice and provision discute to a subgrotive and responsibilities within the framework of case that and provision di supportive and<	LAUREL	BROOK REHABILIT	CION AND REALINCARE CENT		Μ	IOUNT LAUREL, NJ 08054		
 RP notification with barriers or delays for further guidance. No further findings found. This deficient practice was identified for 1 of 1 resident (Resident #255) reviewed for a change in condition and 1 of 5 residents (Resident #7) reviewed for a for measurement of the state of residents (Resident #7) reviewed for a change in condition and 1 of 5 residents (Resident #7) reviewed for a change in condition and 1 of 5 residents (Resident #7) reviewed for a change in condition and 1 of 5 residents (Resident #7) reviewed for a change in condition and 1 of 5 residents (Resident #7) reviewed for a change in condition and 1 of 5 residents (Resident #7) reviewed for a change in condition and 1 of 5 residents (Resident #7) reviewed for further guidance in accordance with professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 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 provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 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 finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and 	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	‹	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF) BE	COMPLETION
		Continued From pare experienced was rescheduled for in a timely m professional standa This deficient practi- resident (Resident ; in condition and 1 of reviewed for This deficient practi- following: Reference: New Jee 45. Chapter 11. Nut Practice Act for the "The practice of nut professional nurse- treating human resp physical and emotion such services as can health counseling, a supportive to or resp and executing med a licensed or other physician or dentist Reference: New Jee 45, Chapter 11. Nut Practice Act for the "The practice of nut physician or dentist Reference: New Jee 45, Chapter 11. Nut Practice Act for the "The practice of nut nurse is defined as responsibilities with finding; reinforcing	Ige 49 (VEXORE 284(9)(1), and (VEXORE 284(9)(1)) or an outpatient (VEXORE 284(9)(1)) nanner in accordance with ards of nursing practice. ice was identified for 1 of 1 #255) reviewed for a change of 5 residents (Resident #7) ice was evidenced by the rsey Statutes Annotated, Title rsing Board. The Nurse State of New Jersey states: rsing as a registered is defined as diagnosing and ponses to actual and potential onal health problems, through ase finding, health teaching, and provision of care torative of life and wellbeing, ical regimens as prescribed by wise legally authorized " rsey Statutes Annotated, Title rsing Board. The Nurse State of New Jersey states: rsing as a registered is defined as diagnosing and ponses to actual and potential onal health problems, through ase finding, health teaching, and provision of care torative of life and wellbeing, ical regimens as prescribed by wise legally authorized "	1	84	RP notification with barriers or dela further guidance. No further finding found. 3. The licensed nurses were re-educated by Director of Nursing/Designee on the need for appropriate care provision with no treatment to include but not limited notifying the clinical provider and F there will be a delay in the complet diagnostic testing such as a STAT doppler and/or outpatient CT scan further guidance in accordance with professional standards of nursing to include documentation in the marecord. The review also consisted education of what timelines are considered for stat orders and imp communication when transportation up for outpatient testing. Staff re-education included those identified the 2567 4. The DON/designee will audit 3 residents with clinical provider orded diagnostic testing to validate for appropriate care provision with no treatment to include but not limited notifying the clinical provider and F there will be a delay in the complet diagnostic testing such as a STAT doppler and/or outpatient CT scan accordance with professional stan nursing practice to include docum in medical record. Variances will b	delay in to P if tion of venous for th practice edical of roved of is set fied in to RP if tion of venous in delay in to RP if tion of venous of of th practice edical of	
		counseling and pro restorative care, un	vision of supportive and der the direction of a			monthly x 2 months. The findings	of the	
registered nurse or licensed or otherwise legally authorized physician or dentist."audits will be submitted by the Director of Nursing to the QAPI Committee for review								

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	FORM	03/31/2025 APPROVED 0938-0391							
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BUILD	ING _		(
		315524	B. WING	-		10/*	16/2024		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD				
LAUREL BROOK REHABILITATION AND HEALTHCARE CENT			R MOUNT LAUREL, NJ 08054						
(X4) ID			ID			(X5)			
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE		
F 684	Continued From pa	ae 50	F6	84					
		5			and recommendation monthly for 3				
		ident #255's Admission			months or ongoing until compliance	e is			
		(an admission summary), sident was admitted to the			sustained				
	facility with diagnos	is which included but were not							
	limited to; NJ Ex Or , NJ Ex Order								
) and							
	NJ Ex Order 26.4(b	(1)), and ^{NJ EX Order 26.4(b)(1)}							
	, and a h	istory of Wex order 26.							
	A review of Resident #255's comprehensive Minimum Data Set (MDS), an assessment tool, dated review for Mental Status (BIMS) score was ref Interview for Mental Status (BIMS) score was fully out of 15, and indicated that the resident was fully NJ Ex Order 26.4(b)(1). The remainder of the MDS was still in progress and was not able to be viewed.								
	comprehensive Car entry with a Focus of related to u reduced risk for NJ daily throug Interventions includ worsening signs an and infection: NJ Ex NJ Ex Order 26.4(b)(1), etc. Report to physi indicated; and Obta (testing) work as or physician and RN ((Licensed Practical A review of Resider	nt #255's individualized re Plan (ICCP) revealed an of: I have WEX OTCLE 264(D)(1) inspecified, Goal: I will be at EX Order 26.4(b)(1) gh the review date. led: Monitor for new or d symptoms of complications Order 26.4(b)(1) WEX OTCLE 28.4(D)(1) NJ EX OTCLE 26.4(D)(1) WEX OTCLE 28.4(D)(1) NJ EX OTCLE 26.4(D)(1) WEX OTCLE 28.4(D)(1) , ician if noted and follow-up as in and monitor lab/diagnostic dered. Report results to Registered Nurse)/LPN Nurse) follow-up as indicated.							
	STAT NJ Ex Order								

Facility ID: NJ03015

DEPART	FORM	APPROVED					
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTIO		MB NO. 0938-0391 (X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	1 ° '	G			PLETED
							0
		315524	B. WING			10/	16/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS 3718 CHURCH R	S, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	MOUNT LAURE			
(X4) ID		TEMENT OF DEFICIENCIES	ID		IDER'S PLAN OF CORRECTIO		(X5)
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		CORRECTIVE ACTION SHOULI EFERENCED TO THE APPROF DEFICIENCY)		COMPLETION DATE
			1		-		
F 684	Continued From pa	ge 51	F 68	4			
	A review of a Nurse	Practitioner (NP) Note within					
	Resident #255's Pro	ogress Notes revealed an					
		at 11:38 AM, written by Nurse cated: "This patient is being					
	seen per nursing re	quest. Per nursing the patient					
		me NJ Ex Order 26.4(b)(1) and seen today in bedreports					
		to his/her					
	reports this was not	ticed yesterday by his/her					
		he patient denies change in patient denies NJ Ex Order 26.4(b)(1)					
	Or NJ Ex Orde	^{26.4(b)(1)} Further review of the					
	Nurse Practitioner	Note revealed interventions					
	which included: NJEX	to ^{NEX006226} Plan: Nursing:					
		reviewed with nursing					
	A review of a Health	n Status Note entry written by					
	Licensed Practical	Nurse/Unit Manager (LPN/UM)					
	#1, dated WEXONE 2000	at 6:01 PM revealed, and reports <mark>NJ Ex Order 26.4(b)(1)</mark>					
	(NJ Ex Order 25.4(b) Company	name redacted) has not done					
		^{1x Order 26.4(b)(1)} NJ Ex Order 26.4(b)(1)					
	with with bedside requesting	(Responsible Party) at NJ Ex Order 28.4(b)(1) . NP made aware.					
	dispatched at 5						
	A review of an SBA	R (Situation, Background,					
	Assessment, Recor	mmendation) note written by					
		1 (7:01 PM) revealed: der 26.4(b)(1), Background:					
	recent NJ Ex Order 26.4(b)(1)	, Assessment: NJ Ex Order 26.4(b)(1)					
	, Rec	commendation: send to NEX for					
		ent), Response: er per request." Further review of the					
	EHR revealed that	there was no documented					
		cility contacted the hospital to					
	provide or receive a	a clinical update on the					

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DEPART	FORM	APPROVED						
		& MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		045504					С	
		315524	B. WING			10/	16/2024	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054			
0(0)15		TEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTI		(75)	
(X4) ID PREFIX TAG			ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 684	Continued From pa	ao 52	F 68	24				
1 004	resident's condition	-	FO	54				
	resident's condition							
	A review of a New	Jersey Universal Transfer						
		ommunicates pertinent,						
		tient care information at the						
		ween the health care facilities)						
		me of transfer was on /I. The resident's ^{NJ Ex Order 28.4(b)(1)}						
	at 7.00 Ph	A. The resident's						
	reason for transfer	(must include brief medical						
		changes in physical function or						
		Diagnosis, Secondary						
	Diagnosis, and	Condition sections of the						
		in as required to alert the						
		the resident's clinical status at to a higher level of care.						
		to a higher level of care.						
	During an interview	with the surveyor on 10/09/24						
		JM #1 stated that she believed						
	that Resident #255	had a <mark>NJ Ex Order 26.4(b)(1)</mark> .						
	LPN/UM #1 stated	that the ^{us. fo} put the order in for						
	the STAT	the computer. LPN/UM #1						
		ched out to the third party ia the portal, faxed a face						
	company v	n Record) and called the						
		#1 stated that when she						
		for an ETA (estimated time of						
	arrival) they could n	ot give me one, they stated						
		not a specific ETA. LPN/UM						
		rder was time stamped and						
		e contacted the						
		around 12:00 PM or 12:15						
		as not available. LPN/UM #1						
	stated that around \$	5:00 PM or 6:00 PM, she						
	called the NJ Ex Order 25.4(b)	company back and they said						
	the wait time was 9	0 minutes. LPN/UM #1 stated						
		esponsible party arrived and						
	did not want to wait	. LPN/UM #1 stated that the						

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DEPART	FORM	APPROVED					
		& MEDICAID SERVICES	. <u> </u>			DMB NO. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		E CONSTRUCTION	СОМ	E SURVEY PLETED
		315524	B. WING				C 16/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	:	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETION DATE
F 684	Continued From pa	ge 53	F 68	84			
	imaging company a the resident was se	arrived about 20 minutes after ent to ^{NJ Ex Order 28.4(b)(1)}					
	the resident was see At that time, LPN/U #255 "complained the day, and at arou and Water ". LPN/UM #1 a Water confirmed by N Exore surveyor asked why status and confirmed documented in the LPN/UM #1 stated in the EHR, then we we update note. The set LPN/UM #1 review demonstrate where charted. LPN/UM # that there was one that she did a follow see where the resid on hold and admiss out of the system of stated that night shi confirm resident stated						
	At that time, LPN/U have a STAT order, completed within ar up until about three the user was notified that it would be oka end of the night the go out for evaluation	have documented the call to e resident' status". IM #1 further stated that if we it was expected to be in hour or two, and give grace hours. LPN/UM #1 stated that of the delay, and she stated by if it were not done by the in the resident would need to n. LPN/UM #1 stated, "I did conversation anywhere."					

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DEPAR	FORM	APPROVED						
		& MEDICAID SERVICES				OMB NO. 0938-0391		
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Y Z			(X3) DATE SURVEY COMPLETED		
		315524	B. WING				C 16/2024	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		718 CHURCH ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684	Continued From pa	ge 54	F 6	84				
	During an interview at 11:43 AM, the Nu stated that she was facility since stated NP ordering a STAT was do STAT we ordered it." NP a when it was not ord sent the resident out that she was inform) that the state of the state NP #3 who was pre- we attended a Return if there was anythin with root cause ana resident was admitted NP #3 who was pre- we attended a Return if there was anythin with root cause ana resident was admitted that we did not realind order STAT. NP #1 that the stated that it protocol for nursing conversation. During an interview at 10:44 AM, the U. stated that when an diagnostic test nurs and notified the pro- a STAT stated that was com- picture of the patier generally within four	with the surveyor on 10/09/24 urse Practitioner (NP) #1 contracted to work at the or WEXORE 204(0)(). When the #2 about the process for within the surveyor on 10/11/24 with the surveyor on 10/11/24						

Facility ID: NJ03015

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		AND HUMAN SERVICES				FORM	: 03/31/2025 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	CON	E SURVEY IPLETED
		315524	B. WING	i			C 16/2024
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	I 1	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) Completion Date
F 684	care provider know recommendations. At that time, the set Jersey Universal Tr completed and sen also called report to advise of the reason that he would have and document it. Th expect the nurse to document in a narra assessment sheet. usually called the he outcome in the clini 2. During the initial at 11:53 AM, the su lying in bed awake. concern regarding the he/she was NJEXOTER appointments for di transport. The reside tray in front of them resident stated I has giving me NJ EX OTER A review of Resider admission summar was admitted to the included but were n and NJ Ex Order 26 A review of Resider Minimum Data Set	four hours, we let the health and they make further four hours, we let the health and they make further four hours make further further stated that the New ansfer form should be t with the resident, and we to the ER (emergency room) to n for transfer. The stated expect for the nurses to do it the stated that he would do a pain assessment and ative note or on the pain The stated that we ospital and documented the cal record. tour of the facility on 10/08/24 rveyor observed Resident #7 The resident expressed transportation and stated that that was untouched. The ve we stated that their breakfast that was untouched. The ve we stated that the resident that was untouched. The ve we stated that the resident facility with diagnosis which to t limited to: we correct stated NJ Ex Order 26.4(b)(1)	F	684	4		

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938- STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE		
	Y	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED	COMPLETED	
C		
315524 B. WING 10/16/202	4	
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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4)		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE		
F 684 Continued From page 56 F 684		
Brief Interview for Mental Status score of we out		
of 15, which indicated that the resident was fully NJ EX Order 26.4(b)(1). Review of Section Netroner28		
revealed that the		
resident had an <mark>NJ Ex Order 26.4(b)(1)</mark> of ^{NJ Ex O} rder 28.4(b)(1) or more in		
more in the last month or MExorder 284(6)(1) or more in the last six months.		
A review of Resident #7's Order Summary Report revealed an order dated		
patient set up for NJ Ex Order 26.4(b)(1) of ^{NJ Ex Order 26.4(b)(1)}		
due to <mark>NJ Ex Order 26.4(b)(1)</mark>		
A review of a Nurse Practitioner Note dated		
Nurse Practitioner (NP) # 2		
documented"pending NJ Ex Order 26.4(b)(1)		
due to NJ Ex Order 26.4(b)(1) , reviewed U.S. FOIA (b) (6))		
recommendations, recommending WEX OTHER 2014/0001 in 3		
months-patient is currently refusing Wexoder 25.4(b)		
Further review of Resident #7's Electronic Health		
Record (EHR) revealed a Nurse Practitioner Note dated Nex Compared at 11:12 AM, which detailed:		
"Interventions:NJ Ex Order 26.4(b)(1)		
after 12 am on ^{NEXODER} for NEXODE , pending CT <mark>NJ Ex Order 26.4(b)(1)</mark>		
due to NJ Ex Order 26.4(b)(1)		
Further review of Resident #7's EHR revealed a		
Health Status Note dated Heading at 13:53 (1:53		
PM) which indicated: "Patient as unable to go for Westonerstated due to transport having wrong address.		
Pt and Scheduler made aware. Pt will be		
rescheduled. No orders at this time. Care ongoing".		

	MENT OF HEALTH		FORM	APPROVED				
		& MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315524	B. WING				C 16/2024	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		718 CHURCH ROAD IOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 684	Continued From pa	ge 57	F 68	84				
	Acknowledgement I AM, that was written indicated, "unit clerk 	esident #7's EHR revealed an note dated ^{MEXOREFORM} at 8:40 n by Unit Clerk (UC) #1 and k received a call from they needed a new ^{METORS} faxed Update was made Trip						
	Health Status Note which indicated, "Tr resident to state of 10 an could not sit with re- appointment	esident #7's EHR revealed a dated dated at 3:37 PM ransport arrived to escort appointment, appointment n, transportation stated they sident until scheduled stated that pt needed to to arriving. Transport stated resident at present time and a be scheduled."						
	Nurse Practitioner N (10:14 PM) which in	esident #7's EHR revealed a Note dated ^{Nex one 244001} 22:14 ndicated"Interventions: nding <mark>NJ Ex Order 26.4(b)(1)</mark> , ^{4(b)(1)} ."						
	Nurse Practitioner N AM, which indicated know when he/she The patient had out NJ Ex Order 26.4(b) was recomme want to do wexover Th NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)	ended. The patient does not ne patient reports ongoing), ^{NJ Ex order 20:4(0)(1)} denies						
	Further review of R	esident #7's EHR revealed a						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		(
		315524	B. WING				16/2024
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 18 CHURCH ROAD		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG				¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Nurse Practitioner M PM which indicated NJ EX Order 26.4(b)(1), current symptoms of During an interview at 11:30 AM, UC #1 few issues with mis not transportation re Resident #7 was so nursing was confus was scheduled two resident to complete driver away. UC #1 assigned to that unit was not resch During an interview at 11:39 AM, UC #2 up transportation fo need to follow up. During an interview at 11:59 AM, NP #2 for Resident # resident did not mat When the surveyor responsibility to follow was complete would handle it." NF and stated, "We wri staff handled it from During an interview at 12:05 PM, Licens stated that she review Notes for nurse com	Note dated NECONSTRATE at 2:20 : " NECONSTRATE pending outpatient pending NEX Order 26.4(b)(1) . No or NECONSTRATE on today's exam" with the surveyor on 10/09/24 stated that Resident #7 had a sed appointments which were elated. UC #1 stated that cheduled for a NECONSTRATE and ed as to why the appointment hours early to allow for the e the NJ EX Order 26.4(b)(1)) and the nurse sent the stated that she was no longer it and was unsure if the NEC eduled. with the surveyor on 10/09/24 stated that she has not set or Resident #7, and would with the surveyor on 10/09/24 stated that she ordered a NECONSTRATE with the surveyor on 10/09/24 stated that she ordered a NECONSTRATE NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET NET	F 68	84			

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	MENT OF HEALTH		FORM	APPROVED			
						OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		CONSTRUCTION		
						(C
		315524	B. WING			10/	16/2024
NAME OF F	PROVIDER OR SUPPLIER	•	· · · · · · · · · · · · · · · · · · ·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		18 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX TAG	((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	:	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 684	NJEXOTOGR254(0)1. LPN #4 ft	urther stated that there was an consecutive, re: re were no results in the	F 68	84			
	During an interview with the surveyor on 10/09/24 at 1:12 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) # 4 stated that there must have been a miscommunication because the stated sets the pick up time, and she did not alert the nurse of a need to get the stated that we should have rescheduled the stated that we should have rescheduled the for another day and the should have been notified. LPN/UM #4 stated, "That is a delay, we have to rectify it, and set it up for him/her."						
	Acknowledgement (2:30 PM) that spec [sic.] NJ Ex Order 20 present. Will f/u (fol second Acknowledg 14:32 (2:32 PM) inc am. Needs to be the " The surv	ht #7's EHR revealed an note dated NECODEr264(b) at 14:30 cified:'NECODEr264(b) of NECODEr264(b) 24(b)(1)Aide needs to be llow up) with transport. A gement note dated NECODER264(b)(1) dicated:"Appt. NECODER264(b)(1) ere NJ EX Order 26:4(b)(1) to NECODE veyor noted that the was rescheduled after					
	at 11:02 AM, the U. that when a ^{Meroceteact} verified the order ar to our scheduler to implement the diag transportation was accommodate the r unable to take the r	with the surveyor on 10/15/24 S. FOIA (b) (6)) stated was ordered the nurse and the information was given schedule it. Then we nostic and verify that ordered and they can resident. If transport were resident, we notify the provider chedule. The stated that					

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		AND HUMAN SERVICES				APPROVED	
			(X2) MULT	IPI F			E SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	` ´				PLETED
							0
		315524	B. WING			10/ [.]	16/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		OUNT LAUREL, NJ 08054		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
F 684	Continued From pa	ae 60	F 68				
1 004		e typically verify through a	FOC	54			
	chart check or docu	mentation. The stated					
	there was a response	sibility on the provider to follow					
	up and see if it were should have been d	e done. The stated that it locumented in a progress					
	note. The US.FOM stat	ed that we have not identified					
		ause of why the was					
	not reordered.						
		ated facility policy, "Request for					
	Diagnostic Services	" revealed the following:					
	Orders for diagno	stic services will be promptly					
		ucted by the physician's order.					
	Emergency request	ts must be labeled "stat" to					
	assure that prompt						
	A review of the facil	ity policy, "Lob and Diagnostic					
		ity policy, "Lab and Diagnostic al Protocol" (Revision					
		vealed the following:					
	The physician will is	dentify and order diagnostic					
		ed on the resident's diagnostic					
	and monitoring nee						
	The staff will proces	ss test requisitions and					
	arrange for tests.	sa teat requisitions and					
	-						
		gnostic radiology provider, or will report results to the					
	facility.						
	A	6 . 4					
		fy the urgency communicating Physician based on physician					
		sness of any abnormality, and					
	the individual's curr						
	A nurse will try to de	etermine whether the test was					
	A nurse will try to de	etermine whether the test was					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		315524	B. WING _			C 16/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	done: a. As a routine scree b. To assess a cond of signs and sympto (1)The reason for urgency of acting up Nursing staff will of to help identify situal physician notification test results: Whether the physic notified as soon as Whether the physic notified as soon as Whether the results physician regardles is, abnormal result if any other factors). Whether the resided unclear or he/she h acute illness or chai improving, or there comparison. Facility staff shout when, how, and to v provided and the re in the Progress Not record and not on the test results could be information such as situation, current sy prognosis, etc. Physician's or nurse how tests have bee should communicat and/or Medical Dire Such concerns or d prevent timely, clinic of a current result of	en or follow-up; dition change or recent onset oms; getting a test often affects the pon the result. consider the following factors ations requiring prompt in concerning lab or diagnostic ian has requested to be a result is received. s should be conveyed to a s of other circumstances (that is problematic regardless of int/patient's clinical status is as signs and symptoms of nge and is not stable or are not a previous result for ld document information about whom the information was sponse. This should be done es section of the medical he lab results report, because e correlated with other relevant the resident's overall imptoms, advance directives, es who have concerns about in handled and reported the such concerns to the DON ctor. isagreements should not cally appropriate management	F 68			

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		AND HUMAN SERVICES	FORM APPRO OMB NO. 0938-(APPROVED	
	OF DEFICIENCIES						0938-0391 E SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '		ECONSTRUCTION	· ·	PLETED
						0	c
		315524	B. WING			10/1	16/2024
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		IOUNT LAUREL, NJ 08054		
(X4) ID		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	-	(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	`	CROSS-REFERENCED TO THE APPROPR		DATE
					DEFICIENCY)		
F 684	Continued From pa	ae 62	F 6	8 4			
1 004		dopted November 2023)	10	04			
	revealed the followi	• •					
	Services provided to	o the resident that outline a					
		ent's medical or mental					
		locumented in the resident's					
	medical record.						
	All changes in a re	esident's status are to be					
	promptly communic	ated to the physician for					
	further review, evaluation appropriate.	uation and interventions as					
	appropriate.						
		ity policy, "Transfer or					
	Discharge, Facility- 2022) revealed the	Initiated" (Revision October					
		lono milg.					
		be permitted to remain in the					
		ransferred or discharged or discharge is necessary for					
		re and the resident's needs					
		his facility;the safety of the					
		cility is endangered due to the al status of the resident;					
		include documentation of					
	resident prior to tran	tion and preparation of the					
		tions or precautions for					
	ongoing care, as ap	propriate such as:					
	special risks such						
		ion necessary to meet the cluding but not limited to:					
		uding baseline and current					
	mental, behavioral,	and functional status;					
		ergies; medications (including					
		t recent relevant labs, other d recent immunizations; a					
		t's discharge summary; and					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		315524	B. WING			C 16/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	IR	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	any other document ensure a safe and en- Documentation of F Discharge: When a resident is from the facility, the documented in the The basis for the tra- resident is being tra- because his or her facility, documentat resident needs that attempt to meet tho facility's service (s) those needs; The date and time The new location of The mode of transp A summary of the re physical and menta Disposition of perso ascertain an accur condition, which will communication betw	tation, as applicable, to effective transition of care. Facility-Initiated Transfer or transferred or discharged following information is medical record: ansfer or discharge; If the insferred or discharged needs cannot be met at the ion will include: the specific cannot be met; the facility's se needs; and the receiving that are available to meet e of the transfer or discharge; the resident; portation; esident's overall medical, I condition;	F 684	4		
F 686 SS=D	CFR(s): 483.25(b)(§483.25(b) Skin Inte §483.25(b)(1) Press	Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity	F 68	6		11/21/24
	resident, the facility	must ensure that- es care, consistent with				

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		AND HUMAN SERVICES			FORM	03/31/2025 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	TIPLE CONSTRUCTION	COME		
		315524	B. WING		C 10/16/2024		
	PROVIDER OR SUPPLIER	TION AND HEALTHCARE CENTI	ER	STREET ADDRESS, CITY, STAT 3718 CHURCH ROAD MOUNT LAUREL, NJ 080	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 686	pressure ulcers and ulcers unless the in demonstrates that to (ii) A resident with p necessary treatmer with professional st promote healing, pu new ulcers from de This REQUIREMEN by: Based on observat and review of other was determined that and document a treatment order, an interventions to pre NJ EX Order 26.4(b)(1) upon NJ EX Order 26.4(b)(1) upon NJ EX Order 26.4(b)(1). Th identified for 1 of 2 reviewed for NJ EX Order This deficient pract following: On 10/8/24 at 10:18 the facility the surve lying awake in bed noted at the foot of that they had a "receive care or timely manner wheat to 7 AM shift. The r incidence occurred they waited 3 hours	ands of practice, to prevent d does not develop pressure dividual's clinical condition they were unavoidable; and pressure ulcers receives and and services, consistent andards of practice, to revent infection and prevent veloping. NT is not met as evidenced tion, interviews, record review, pertinent documentation, it at the facility failed to perform assessment, obtain a d implement timely vent the development of a n the identification of an (1) for a resident previously sk for the N EX OTHER 264(0)(1) of is deficient practice was residents (Resident #101) der 26.4(b)(1). ice was evidenced by the B AM, during the initial tour of eyor observed Resident #101 with NJ EX Order 26.4(b)(1) the bed. The resident stated S AM , during the initial tour of eyor observed Resident #101 with NJ EX Order 26.4(b)(1) the bed. The resident stated S AM , during the initial tour of eyor observed Resident #101 with NJ EX Order 26.4(b)(1) the bed. The resident stated S AM , during the initial tour of eyor observed Resident #101 with NJ EX Order 26.4(b)(1) the bed. The resident stated S AM , during the initial tour of eyor observed Resident #101 with NJ EX Order 26.4(b)(1) the bed. The resident stated S AM , during the initial tour of eyor observed Resident #101 with NJ EX Order 26.4(b)(1) the bed. The resident stated		 ANJ EX Order 26.4(b)(1 evaluation was c Resident #101 by lice 10/15/24 with findings clinical provider and c transcribed and imple #101 care plan was a reflect current status, preferences. Current residents impairments have the affected. The DON/de an audit of residents v impairments, and/or h to validate an updated evaluation had been of provider notification, of and care plan interven address resident statu Variances were addres 3. The DON/designed Unit Managers and lice facility Wound care pu not limited to perform skin assessments, ob orders, implementing to prevent the develop ulcers upon the identi 	ompleted for insed nurse on a reviewed with orders received, mented. Resident lso updated to orders and with skin integrity epotential to be esignee conducted with skin nad treatment orders d skin and pain completed, clinical orders were in place, ntion were in place, ntion were in place to us and preferences. essed. ee re-educated the censed nurses on the rogram to include but ing and documenting otaining treatment timely interventions oment of pressure		

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	ripi f			0938-0391
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		045504				C	
	PROVIDER OR SUPPLIER	315524	B. WING	ет	REET ADDRESS, CITY, STATE, ZIP CODE	10/1	6/2024
					18 CHURCH ROAD		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		OUNT LAUREL, NJ 08054		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETION DATE
				\square	DEFICIENCY)		
F 686	Continued From no		F 00				
F 000		ge oo ission summary), revealed	F 68	86	alteration in skin integrity and pain		
		d diagnosis which included but			management.		
	were not limited to;	NJ Ex Order 26.4(b)(1)			The Certified Nurses assistants we		
	and NUEx Order 26	NJ Ex Order 26.4(b)(1), $(4/b)(4)$			re-educated on timely care to includ		
	and NJ Ex Order 26	.4(D)(1).			turning and repositioning. Staff edu included those identified in the 256		
	A review of Resider				4. The DON/designee will comple		
		imum Data Set (MDS), an			audit of 3 residents to validate that		
		ated ^{NEXCOURT 204(0)} revealed that the Interview for Mental Status			conditions are accurately evaluated documented, treatment orders obta		
		out of 15, which indicated that			as indicated, implemented upon	ineu	
	the resident was NJ	Ex Order 26.4(b)(1), Further			identification and receipt of orders a		
	review of the MDS,	in Section NJ Ex Order 26.4(b)(1),			pain management is in place. In ad		
	heen at risk for NJEX	esident was identified to have Order 26.4(b)(1) development but			3 residents will be reviewed or inter for timely care to include turning an		
	did not have NJ Ex				repositioning. Variances will be	u	
					addressed. These audits will be		
	A review of Resider	nt #101's Care Plan revealed			conducted weekly x 4 weeks, then monthly x 2 months. The findings o	fthe	
		with a Focus: I have a			audits will be submitted by the Dire		
	Potential for NJ Ex Ord	ler 26.4(b)(1) related to NJ EX Order 26.4(b)(1)			Nursing to the QAPI Committee for	review	
	history of NJ Ex Order 20	6.4(b)(1) <mark>,</mark> NJ Ex Order 26.4(b)(1), Ex Order 26.4(b)(1). A Goal of: I will			and recommendation monthly for 3		
		or NJ Ex Order 26.4(b)(1). A Goal of: T Will or NJ Ex Order 26.4(b)(1) daily			months or ongoing until compliance sustained	; IS	
		date. Intervention/Tasks			Sustained		
		IJ Ex Order 26.4(b)(1) to					
		ast every 2 (two) hours, more d requested, Notify nurse					
	immediately of NJEX C						
	NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)	etc. noted during care,					
		rsening signs/symptoms of					
) NJ Ex Order 2	erations: NJ Ex Order 26.4(b)(1) 6.4(b)(1)), ^{NJ Ex Order 26.4(b) NJ Ex Order 26.4}					
), NJ Ex Order 26.4(b)(1					
		, NJ Ex Order 26.4(b)(1), ^{NJ Ex Order 2}					
	follow-up as indicate	physician if noted and					
		сч.					
	A review of Resider	nt #101's Treatment					

If continuation sheet Page 66 of 171

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: 315524 (X2) MULTIPLE CONSTRUCTION A. BUILDING (X2) MULTIPLE CONSTRUCTION A. BUILDING (X2) MULTIPLE CONSTRUCTION A. BUILDING (X2) MULTIPLE COMPLETED To B. WING (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED TO B. WING (X3) DATE SURVEY COMPLETED TO COM						FORM	APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 315524 B. WING C 10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD (X4) JD PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LGC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION MOUNT LAUREL, NJ 08054 (X4) JD PREFIX Continued From page 66 Administration Record (TAR) revealed a treatment order dated Streament at 5:00 PM, for NJ Ex Order 26.4(b)(1) PREFIX TAG F 686 During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Numers of on their ustormation and received (JN Ex Order 26.4(b)(1) F 686 During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Numers of on their ustormation dated that Resident #101 had interview of the order 50.4(b)(1) F 686 During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Numers of on their ustormation date of the resident % mated that the esident % and she further stated that the ustormation did not entail [] Excource 26.4(b)(1) bis addet that the esident % mated that the profile the treatment order for mated that the profile for the resident % treatment administration Record (TAR). When F 686	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A 315524 B NAME OF PROVIDER OR SUPPLIER LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 686 Continued From page 66 Administration Record (TAR) revealed a treatment order dated "Formation" at 5:00 PM, for NJ Ex Order 26.4(b)(1) Apply to NJ Ex Order 26.4(b)(1) Image an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had "Exceeded on their During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had "Exceeded on their During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that the "Exceeded Nurse (LPN) #9 stated that the resident's last "Exceeded Nurse (LPN) #9 stated that the resident's last "Exceeded Nurse (LPN) #9 stated that the surveyor asked if she had received (Nurse material Nurse order 26.4(b)(1) were identified and she further stated that the "Exceeded Nurse Stated that the "Exceeded Complaints" documented on the resident's Treatment Administration Record (TAR). When the surveyor asked if she had received complaints of delayed care on the 11-7 shift in the past two months, but it was getting better." A review of Resident #101's TAR and Physician Order's failed to contain a "Exceeded Complaints about delayed care on the 11-7 shift in the past two months, but						
10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AUME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AUME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) (%) F 686 Continued From page 66 Administration Record (TAR) revealed a treatment order dated F 686 F 686 During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had F 686 During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had F 686 Outring an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had F 686 Outring an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed that the wrinto identified that no new NLEX OTCH 26:40(0)() wrer				1 ° '			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (va) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILLS BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WILLS THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WILLS CIDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WILLS CIDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WILLS CIDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WILLS CIDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WILLS CIDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WILLS CIDENTIFYING INFORMATION) ID PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WILLS CIDENTIFYING INFORMATION) ID PREFIX THE TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WILLS CIDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WILLS CIDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WILLS CIDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WILLS CIDENTIFY OF CIDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WILLS CIDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH D							
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LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER MOUNT LAUREL, NJ 08054 (X4) D 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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (25) COMPLETION DEFICIENCY F 686 Continued From page 66 Administration Record (TAR) revealed a treatment order dated the state of the stat	NAME OF F	PROVIDER OR SUPPLIER					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 686 Continued From page 66 Administration Record (TAR) revealed a treatment order dated***********************************	LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R I			
TAG REGULATORY OR LSCIDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 686 Continued From page 66 Administration Record (TAR) revealed a treatment order dated if tourist at 5:00 PM, for NJ EX Order 26.4(b)(1) F 686 F 686 During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had if courses F 610 F 610 During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had if courses F 610 F 610 Which identified that no new JULEX Order 26.4(b)(1) Were identified, and she further stated that the Uncourses F 626 F 626 Stated that the image for the course of the courses F 626 F 626 F 626							
F 686 Continued From page 66 F 686 Administration Record (TAR) revealed a treatment order dated F 686 Administration Record (TAR) revealed a treatment order dated F 686 NJ Ex Order 26.4(b)(1) Apply to NJ Ex Order 26.4(b)(1) Image: A day for Wexorder 28.4000 for three (3)months. F 686 During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had Wexorder 26.4(b)(1) F 686 Wexorder 26.4000 and received [NJ Ex Order 26.4(b)(1) M and Wexorder 26.4(b)(1) F 686 Image: A day for Wexorder 26.4(b)(1) M and Wexorder 26.4(b)(1) F 686 Image: A day for Wexorder 26.4(b)(1) M and Wexorder 26.4(b)(1) F 686 Image: A day for Wexorder 26.4(b)(1) M and Wexorder 26.4(b)(1) F 686 Image: A day for Wexorder 26.4(b)(1) M and Wexorder 26.4(b)(1) F 686 Image: A day for Wexorder 26.4(b)(1) M and Wexorder 26.4(b)(1) F 686 Image: A day for Wexorder 26.4(b)(1) M and Wexorder 26.4(b)(1) F 686 Image: A day for Wexorder 26.4(b)(1) M and Wexorder 26.4(b)(1) F 686 Image: A day for Wexorder 26.4(b)(1) M and Wexorder 26.4(b)(1) F 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7							
Administration Record (TAR) revealed a treatment order dated 15000 EM for NJ Ex Order 26.4(b)(1) Apply to NJ Ex Order 26.4(b)(1) times a day for NEX Order 26.4(b)(1) times a day for NEX Order 26.4(b)(1) During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had 14 Order 26.4(b)(1) NEX Order 26.4(b)(1)) and NEX Order 26.4(b)(1)) and NEX Order 26.4(b)(1) were identified that no new NEX Order 26.4(b)(1) Were order 26.4(b)(1) Were order 26.4(b)(1) Were order 26.4(b)(1) Were order 26.4(b)(1) Were order 26.4(b)(1) were identified that no new NEX Order 26.4(b					DEFICIENCY)		
Administration Record (TAR) revealed a treatment order dated 15000 EM for NJ Ex Order 26.4(b)(1) Apply to NJ Ex Order 26.4(b)(1) times a day for NEX Order 26.4(b)(1) times a day for NEX Order 26.4(b)(1) During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had 14 Order 26.4(b)(1) NEX Order 26.4(b)(1)) and NEX Order 26.4(b)(1)) and NEX Order 26.4(b)(1) were identified that no new NEX Order 26.4(b)(1) Were order 26.4(b)(1) Were order 26.4(b)(1) Were order 26.4(b)(1) Were order 26.4(b)(1) Were order 26.4(b)(1) were identified that no new NEX Order 26.4(b	E 000		22				
treatment order dated at 5:00 PM, for NJ Ex Order 26.4(b)(1) Apply to NJ Ex Order 26.4(b)(1) times a day for NJ Ex Order 26.4(b)(1) times a day for NJ Ex Order 26.4(b)(1) times a day for NJ Ex Order 26.4(b)(1) During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had VEXORER 0 on their NEXTORER 26.4001 and received NJ Ex Order 26.4(b)(1)) and VEXORER 26.4001 daily. LPN #9 stated that the resident's last NEX Order 26.4(b)(1) which identified that no new NJ Ex Order 26.4(b)(1) were identified, and she further stated that the NEXTORER 26.4001 did not entail NUEX Order 26.4(b)(1) were identified that no new NJ Ex Order 26.4(b)(1) were identified that no ne	F 080	· ·	-	F 68	6		
NJ Ex Order 26.4(b)(1) Apply to NJ Ex Order 26.4(b)(1) times a day for NJ Ex Order 26.4(b)(1) for three (3)months. During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had Naccomestant on their NJ Exorder 20.4(b)(1)) and Precised Practical Nurse (LPN) #9 stated that Resident #101 had Naccomestant on their NJ Exorder 20.4(b)(1)) and Precised NJ Ex Order 26.4(b)(1)) and Naccomestant was or Naccomestant on their Nurse order 20.4(b)(1) was or Naccomestant on the new NJ Ex Order 26.4(b)(1) were identified, and she further stated that the Nurse Naccomestant the INFORMATION of the resident for Naccomestant of the INFORMATION of the resident for Naccomestant the		treatment order dat	ed ^{Mexoreexand} at 5.00 PM for				
times a day for WEX Order 28.4(b)(1) for three (3)months. During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had WEX Order 26.4(b)(1)) and WEX Order 26.4(b)(1)) and WEX Order 26.4(b)(1)) and WEX Order 26.4(b)(1) which identified that no new NJ EX Order 26.4(b)(1) were identified, and she further stated that the NEX Order 26.4(b)(1) LPN #9 stated that the WEX Order 26.4(b)(1). LPN #9							
times a day for WEX Order 28.4(b)(1) for three (3)months. During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had WEX Order 26.4(b)(1)) and WEX Order 26.4(b)(1)) and WEX Order 26.4(b)(1)) and WEX Order 26.4(b)(1) which identified that no new NJ EX Order 26.4(b)(1) were identified, and she further stated that the NEX Order 26.4(b)(1) LPN #9 stated that the WEX Order 26.4(b)(1). LPN #9		Americate					
three (3)months. During an interview with the surveyor on 10/09/24 at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had ^{INTERCOMPTINENT} on their ^{INTERCOMPTINENT} and received <mark>NJ Ex Order 26.4(b)(1)</mark>) and ^{NTERCOMPTINENT} daily. LPN #9 stated that the resident's last ^{NTERCOMPTINENT} was on ^{NTERCOMPTINENT} , which identified that no new ^{NJ Ex Order 26.4(b)(1)} were identified, and she further stated that the ^{NTERCOMPTINENT} treatment order for ^{NTERCOMPTINE} stated that the ^{NTERCOMPTINE} treatment order for ^{NTERCOMPTINE} documented on the resident's Treatment Administration Record (TAR). When		Apply to times a	a day for NJ Ex Order 26.4(b)(1)				
at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had ^{NUECONEF264(D)} on their ^{NUECONEF264(D)()} and received NJ Ex Order 26.4(b)(1)) and ^{NUECONEF264(D)(1)} daily. LPN #9 stated that the resident's last ^{NUECONEF264(D)(1)} was on ^{NUECONEF264(D)} , which identified that no new ^{NJ Ex Order 26.4(b)(1)} were identified, and she further stated that the ^{NUECONEF265(D)(1)} did not entail NJ Ex Order 26.4(b)(1). LPN #9 stated that the ^{NUECONEF264} treatment order for ^{NUECONEF} documented on the resident's Treatment Administration Record (TAR). When							
at 12:13 PM, Licensed Practical Nurse (LPN) #9 stated that Resident #101 had ^{NUEXOREF23401} on their ^{NUEXOREF284001} and received NJ Ex Order 26.4(b)(1)) and ^{NUEXOREF284001} daily. LPN #9 stated that the resident's last ^{NUEXOREF284001} was on ^{NUEXOREF2840} , which identified that no new ^{NJ EX Order 26.4(b)(1)} were identified, and she further stated that the ^{NUEXOREF284001} did not entail NJ EX Order 26.4(b)(1). LPN #9 stated that the ^{NUEXOREF28401} treatment order for ^{NUEXOREF} documented on the resident's Treatment Administration Record (TAR). When		Dunin n en internieur					
stated that Resident #101 had ^{WEXORE 26400} on their ^{WEXORE 26400(1)} and received NJ EX Order 26.4(b)(1)) and ^{WEXORE 26400(1)} daily. LPN #9 stated that the resident's last ^{WEXORE 26400(1)} was on ^{WEXORE 26400} , which identified that no new NJ EX Order 26.4(b)(1) were identified, and she further stated that the ^{WEXORE 26400(1)} did not entail ^{NJ EX Order 26.4(b)(1)} . LPN #9 stated that the ^{MEXORE 264} treatment order for ^{WEXORE} documented on the resident's Treatment Administration Record (TAR). When							
) and N Ex Order 28.4(9(1)) daily. LPN #9 stated that the resident's last N Ex Order 28.4(9(1)) was on N Ex Order 26.4(9)(1) which identified that no new NJ Ex Order 26.4(b)(1) were identified, and she further stated that the N Ex Order 26.4(5)(1). LPN #9 stated that the N Ex Order 26.4(b)(1). LPN #9 stated that the N Ex Order 26.4(b)(1). LPN #9 Treatment order for N Ex Order documented on the resident's Treatment Administration Record (TAR). When		stated that Residen	t #101 had ^{NJ Exorder 25.4(0)(} on their				
the resident's last ^{NEX Order 204(b)(1)} was on ^{VEX Order 26.4(b)(1)} which identified that no new <mark>NJ EX Order 26.4(b)(1)</mark> were identified, and she further stated that the NEX ORDER 2010(b) did not entail NJ EX Order 26.4(b)(1). LPN #9 stated that the NEX ORDER treatment order for NEX ORDER documented on the resident's Treatment Administration Record (TAR). When		NJ Ex Order 26.4(b)(1) and rec	eived NJ Ex Order 26.4(b)(1)				
which identified that no new NJ Ex Order 26.4(b)(1) were identified, and she further stated that the NJ Ex Order 26.4(b)(1). LPN #9 stated that the NJ Ex Order 26.4(b)(1). LPN #9 documented on the resident's Treatment Administration Record (TAR). When) and Nacoder 2040 the resident's last N	Ex Order 20.4(b)(1) was on NU Ex Order 20.4(b)				
Nutromerzes/(b)(u) did not entail Nutromerzes/(b)(u) LPN #9 stated that the Nutromerzes/Interaction order for Nutromerzes/Interaction Interaction Interaction documented on the resident's Treatment Administration Record (TAR). When Interaction							
stated that the Metocare treatment order for Metocare documented on the resident's Treatment Administration Record (TAR). When							
documented on the resident's Treatment Administration Record (TAR). When							
Treatment Administration Record (TAR). When							
the survey extend if the had received		Treatment Administ	tration Record (TAR). When				
about delayed care on the 11-7 shift in the past		about delayed care	on the 11-7 shift in the past				
two months, but it was getting better."		two months, but it w	vas getting better."				
A review of Resident #101's TAR and Physician		A review of Resider	nt #101's TAR and Physician				
Order's failed to contain a streatment order		Order's failed to con	ntain a Nex order 25.4 treatment order				
LPN #9.			as previously described by				
During an interview with the surveyor on 10/10/24							
at 12:25 PM, Certified Nursing Assistant (CNA) #10 stated that Resident #101 still had a							
their Mexicity that came and went.		their NJ EX Order 2	* that came and went.				
Resident #101 stated that when CNA #10 was							
there he/she received better care. Resident #101 further stated that CNA #10 placed something							

Facility ID: NJ03015

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		AND HUMAN SERVICES			,		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			(. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '			` ́сом	E SURVEY IPLETED C
		315524	B. WING				16/2024
NAME OF F	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		718 CHURCH ROAD NOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	c	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	During an interview at 12:41 PM, Licen Manager (LPN/UM) had NJ Ex Order 26:4(b)(1 N Ex Order 26:4(b)(1) now. LPN/U was only ordered N treatment was in pla CNA #10 reported t N Ex Order 26:4(b)(1) on th stated, "I have to loo stated that the resic his/her NJ Ex Order 20:4(b) A review of Resider dated "Ex Order 26:4(b)(1) and resident had no doo During an interview at 9:49 AM, LPN/U Resident #101's NJ resident permission surveyor. Certified I assisted LPN/UM # his/her side. At that that the resident's N n and on the NJ Ex Order 2 alerted the nurse. C looked at it, and sta she thought." LPN/U	assist the resident with decorrected with the surveyor on 10/10/24 sed Practical Nurse/Unit) # 4 stated that Resident #101). He stated that the resident 's periodically decorrected was not JM #4 stated that the resident ************************************	F 6	86			
	she thought." LPN/ NJ Ex Order 26.4(b)(1),						

Facility ID: NJ03015

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						FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	DEPARTMENT OF HEALTH AND HUMAN SERVICES		(X3) DATE	E SURVEY PLETED			
		315524	B. WING				C 16/2024
NAME OF	PROVIDER OR SUPPLIER						
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R				
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	¢	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF) BE	(X5) COMPLETION DATE
F 686	5:00 AM. CNA #11 : NEX Order 26:4(0)(1) and she every two hours, but change or turn the n LPN/UM #4 stated, been NJ EX Order 22 further stated, "The NEX Order 20:400 AM, LPN # assigned to Reside a report of NJ EX Order morning. LPN #10 s should have been m skilled risk manage completed, and a been m skilled risk manage completed up During an interview at 10:35 AM, the U, stated that upon ide NI EX Order 20:4(0)(1) he w evaluate the area a relayed to the provid the aide told the num nurse should have b and documented it. US FO(A(0)(0) should have well upon the initial stated that the sugge every two hours and resident. The US FO(A)	stated that the resident was a hould have been state to resident yet, since 7:00 AM. "The resident should have 6.4b1 " LPN/UM #4 nurse should have done a hd a risk assessment should ed". with the surveyor on 10/15/24 #10 confirmed that she was nt #101 and had not received 264(D)(1) on the resident this stated that the supervisor hotified of NUEXORE 264(D)(1) , a ment report should have been assessment should have been stated that the supervisor hotification of NUEXORE 264(D)(1) , a ment report should have been with the surveyor on 10/15/24 5. FOIA (b) (6) entification of a NUEXORE 26 or yould have had the nurse nd the information was then	F 68	86			

Facility ID: NJ03015

If continuation sheet Page 69 of 171

DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM	APPROVED
							0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICE: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER AMME OF PROVIDER OR SUPPLIER LAUREL BROOK REHABILITATION AND HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION F 686 Continued From page 69 7:00 AM, and then checked by 9:00 AM idea The "Stock" further stated, "The nurse who wa notified should have evaluated the area and called the provider for a treatment order." A review of a Health Status Note in Resident #101's Electronic Health Record (EHR) date ************************************						Сом	E SURVEY PLETED
	IND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 315524 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CT LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CT (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER (EACH CORR (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER (EACH CORR (EACH CORR (EACH CORR TAG F 686 Continued From page 69 7:00 AM, and then checked by 9:00 AM ideally. The matter further stated, "The nurse who was notified should have evaluated the area and called the provider for a treatment order." F 686 A review of a Health Status Note in Resident #101's Electronic Health Record (EHR) dated ID ID COMPARENTIAL STATES (SIGNAR (DIT)) UEX ORDER 26.4(D)(1) N EX ORDER 26.4(D)(1)). ND/F amily notification made. N EX ORDER 26.4(D)(1)).				C 16/2024		
NAME OF F	NAME OF PROVIDER OR SUPPLIER LAUREL BROOK REHABILITATION AND HEALTHCARE CI (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 686 Continued From page 69 7:00 AM, and then checked by 9:00 AM ideally The USTACK further stated, "The nurse who was notified should have evaluated the area and called the provider for a treatment order." A review of a Health Status Note in Resident #101's Electronic Health Record (EHR) dated NEXTORE at 18:29 (6:29 PM) revealed, "Roundo on resident to assess [SECORE [NJ EX Order 26:4(b)(1)] not or[NJ EX Order 26:4(b)(1)] NEXTORE and [NEX Order 26:4(b)(1) N EX Order 26:4(b)(1)				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R				
				Ν	NOUNT LAUREL, NJ 08054		
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	7:00 AM, and then The transfer further str notified should have called the provider of A review of a Health #101's Electronic H #101's Electronic	checked by 9:00 AM ideally. ated, "The nurse who was e evaluated the area and for a treatment order." h Status Note in Resident lealth Record (EHR) dated 6:29 PM) revealed, "Rounded ss ^[VEX00] [VJ Ex Order 26:4(b)(1)] noted 4(b)(1)). ssment completed. provided. [VJ Ex Order 26:4(b)(1)] with applied, covered with [VEX order 26:4(b)(1)] ly notification made. [V Ex order 26:4(b)(1)] [VJ Ex Order 26:4(b)(1)] was er 26:4(b)(1), Site: [V Ex order 26:4(b)(1)] g as [NJ Ex Order 26:4(b)(1)] g as [NJ Ex Order 26:4(b)(1)] [J BX Order 26:4(b)(1)] g as [NJ Ex Order 26:4(b)(1)] [J BX Order 28:4(b)(1)] [J BX Ord	F	\$86			
	Inspect the skin d	laily when performing or					
	•						

		AND HUMAN SERVICES & MEDICAID SERVICES	FORM APPR OMB NO. 0938		APPROVED		
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPL			SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG _			PLETED
		315524	B. WING _			(10/1	C 16/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		718 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID		TEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR		DATE
	1				DEFICIENCY)		
F 686	Continued From pa	ae 70	F 68	36			
		onal care or ADLs (activities of					
	daily living).						
	Reporting:						
	Notify physician o	f new skin alteration (s) noted.					
	alteration (s) noted.	ian or resident of new skin					
	Report other inform	ation in accordance with					
		ofessional standards of					
	nursing practice.						
		ity policy, "Pressure					
		own-Clinical Protocol" ch 2014) revealed the					
	following:						
	Assessment and Re	ecognition:					
	The nursing staff ar	nd Attending Physician will					
		ent an individual's significant					
		eloping pressure sores; for /, recent weight loss, and a					
	history of pressure						
	In addition, the nurs	se shall describe and					
	document/report the						
	Full assessment of	pressure sore including					
	location, stage, leng	th, width, depth, presence of					
	exudates or necrotion	c tissue;					
	Resident's mobility						
		including support surfaces;					
	and all active diagnosis.						
	the physician will	authorize pertinent orders					
	related to wound tre	eatments, including wound					
	cleansingdressing	gs,and application of topical					

Facility ID: NJ03015

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		AND HUMAN SERVICES			FORI	D: 03/31/2025 MAPPROVED D: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′			TE SURVEY MPLETED
		315524	B. WING	i	10	C)/16/2024
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	IR		718 CHURCH ROAD IOUNT LAUREL, NJ 08054	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686		ge 71 for type of skin alteration.	F	686		
	NJAC 8:39-27.1 (a) Free of Accident Ha CFR(s): 483.25(d)(azards/Supervision/Devices	F	689		11/21/24
	as free of accident §483.25(d)(2)Each supervision and ass accidents. This REQUIREMEN by: Part A: Based on observati and review of pertir determined that the Percention of the provided of the provided interviewed the residents reviewed On 10/9/24 at 12:22 Resident #144's roof NJ Ex Order 26.4(b)(1) observed lying in be window open. At the interviewed the residents for the to assist them. The did not take them	sure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced ion, interview, record review, hent facility documents, it was e facility failed to ensure their rventions were implemented to nd risk(s) for residents who do to ensure resident safety. ice was identified for 1 of 7 for metacommeta (Resident #144). 7 PM, the surveyor entered			1. A second evaluation was immediately completed on Resident #144 on 10/9/24 by the licensed nurse with no adverse effect related to cited occurrence. Resident #144 had a second on 10/11/24 with care plan updated based on evaluation to include NJ EX Order 26.4(b)(1) and second to evaluation to include, 24/7 1:1, NJ EX Order 26.4(b)(1) during mandated locations and times, facility was secure	

Event ID: UBXH11

Facility ID: NJ03015

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					OMB NO.		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			E SURVEY PLETED	
			A. DOILDIN			2	
		315524	B. WING			- 16/2024	
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		10/2024	
				3718 CHURCH ROAD			
AUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER	MOUNT LAUREL, NJ 0805	4		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) Completic Date	
F 689	Continued From pa	ge 72	F 68	39			
1.009	interview with the st the resident pulled show the surveyor a . Resident #14 review the Surveyor a acknowledged the I room was NJ Ex Order? During an interview Certified Nursing As a few months ago s she observed the re "144's incident repo was observed NJ Ex NECOMPRESSION IN the root of the repo was observed The repo was observed The repo was observed The repo was observed the repo "144's incident repo was observed NJ Ex NECOMPRESSION IN the root of the repo was observed the repo "144's incident repo was observed The repo was observed the repo "144's incident repo was observed the repo "144's incident repo was observed the repo manual for the report of residents who was likelihood of serious death could occur to an Immediate Jeop The IJ began on 11 was reported to have	very or on 10/9/24 at 2:19 PM, very or on 10/9/24 at 2:19 PM, very of a red bag to and the resident very discovery 44 stated the facility did not policy with them, and ast time they very in their very (0)(1) at 5:00 AM. r on 10/9/23 at 2:16 PM, the ssistant (CNA #1), stated that she reported to the nurse that esident holding very very and om. A review of Resident order 26.4(b)(1) in their room on and very of Resident order 26.4(b)(1) in their room on and very of a comprehensive as updated. to implement the very very reduce hazard(s) and risk(s) very of all residents. This resulted in	F 68	and maintain decomposition in the second sec	on the facility have the potential to sidents identified wed by the e a. An audit was terviews, a visual sident's permission validate policy, which nited to smoking y the resident ation, current and adherence to storage and gnated areas. a change in e-evaluated and to reflect status. ere noted. d. e-educated on the ng the requirement as during rounds, a for the presence or noncompliance		
	submitted an accep 10/10/24 at 9:51 AM	5:13 PM. The facility otable Removal Plan (RP) on <i>I</i> . The survey team verified		are to be immediately a reported to the Supervis and facility Administrato	sor for physician,		
	continuation of the	of the RP during the on-site on 10/10/24.		follow-up. Licensed Nurses were need to complete a new Residents identified with	v evaluation on		
		as follows. lity's "Smoking" policy dated 4, included, "2. Smoking is only		Residents identified wit smoking status and the plan to reflect current ir needs.	e resident's care		

Facility ID: NJ03015

		& MEDICAID SERVICES					0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
				-		С	
		315524	B. WING			10/1	6/2024
AME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		18 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 689	Continued From pa	ae 73	F 68	39			
F 009	permitted in designa which are located o Smoking is not allow any circumstances. smoking restrictions is determined that ti safely and with avai supervision13. Re- independent smokin keep cigarette, elec- tobacco, and other possession. Only di permitted. All other matches, are prohit On 10/9/24 at 12:27 Resident #144's roo NJ Ex Order 26.4(b)(1) observed lying in be window open. At that interviewed the resi- were not allowed we had to wait for hour room to assist them staff did not take the NJ Ex Order 26.4(b)(1) in On 10/9/24 at 1:15 medical record of R A review of the Adm admission summary	ated resident smoking areas, utside of the building. wed inside the facility under 11. The facility may impose s on a resident at any time if it he resident cannot smoke lable levels of support and esidents who have ng privileges are permitted to thronic cigarettes, pipes, smoking items in their sposable safety lighters are forms of lighters, including bited." 7 PM, the surveyor entered on and smelled a scent. The resident was ed with the fan on and the at time, the surveyor dent who stated that they (Construction) in their room, but they is for the staff to come into the the resident stated that the em (VIEX order 204(D)(1), so they their room. PM, the surveyor reviewed the	F 68	39	In addition, nursing assistants were re-educated by Director of Nursing /Designee on the need to assist res- to smoke in designated areas durin designated times. Staff education included those iden the 2567 Resident Council meeting was held 10/10/24 with a review of the facility smoking policy completed by Direct Life Enrichment. 4. The Administrator/designee will complete an audit of 3 residents whi identified as smokers to validate that timely and accurate evaluations are place, care plan is in place and implemented per evaluation and individualized resident needs and the facility policy is adhered to. Residen plans will also be reviewed to validate resident that had a change in smokes status had an evaluation and care pupdate completed. In addition, a weekly visual audit of resident rooms and interview of res- identified as smokers will be condured social Worker/designee to validate individual plan of care and facility pu- followed. Interview will also validate assistance with staff assistance with smoking per designated times. Vari- will be immediately addressed. The audits will be conducted weekly x 4	sidents g tified in l on / tor of ho are at e in hat the nat the nat the nat care ate ing plan sidents cted by olicy is e timely h iances ese	
	, and ^{NJ Ex Orde} A review of the mos	26.4(b)(1) _, NJ Ex Order 26.4(b)(1) ^{ar 26.4(b)(1)} . It recent quarterly Minimum assessment tool dated			findings of the audits will be submit the Administrator to the QAPI Common for review and recommendation more for 3 months or ongoing until compli- is sustained.	mittee onthly	

Facility ID: NJ03015

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		315524	B. WING				C 16/2024
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	10/	012024
LAUREL	LAUREL BROOK REHABILITATION AND HEALTHCARE CENT				18 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	9/18/24, included the Interview for Mental which indicated a M A review of the ICC VECTORER, for VECTORERSAUL understand that for my NJ Ex Order 26.4(b)(1) was updated on VECTOR intervention. "I am a follow facility policy, in my rood added to the ICCP discovered VECTORERSAUL A review of the Full Reports (incident re- revealed the followi On VECTORERSAUL at 3:00 Nurse (LPN) observe their room. Actions resident was re-edu On VECTORERSAUL at 11:00 VECTORERSAUL at 11:00 VECTORERSAUL at 11:00 VECTORERSAUL at 9:30 A NJ Ex Order 26.4(b)(1) in included NJ Ex Order the resident was ed related to VECTORERSAULT	P included a focus area, dated interventions that included: "I my safety, the facility will store and my "Exoregized" The ICCP and my "Exoregized" The ICCP """"", to include the able to NJ Ex Order 26.4(b)(1), and store all "Exoregized of m." These interventions were after the resident was in the facility three times. Quality Assurance (QA) eport) for Resident #144 ng: D PM, the Licensed Practical ved the resident "Exoregized" in taken included that the ucated on the "Exoregized" policy. D AM, the resident was noted sident admitted to "Exoregized" in taken included that the Iccated on the "Exoregized" in taken included that the ICCP "Exoregized" consultation M, the resident was noted their room. Actions taken er 26.4(b)(1) was notified, and lucated on safety concerns in the room.	F 68	39			
	On were at 12:00 suspected Residen) PM, another resident					

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		AND HUMAN SERVICES				FOR	D: 03/31/2025 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '		E CONSTRUCTION	(X3) DA	ATE SURVEY
		DENTIFICATION NOWDER.	A. BUILDIN	NG _			C
		315524	B. WING			1	0/16/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	NJ Ex Order 26.4(b)(1)	came to the facility and the ucated on safety concerns and	F 68	39			
	member smelled W resident's room, and covering the W Ex O included clinical sta monitor for further b	AM, during rounds, a staff Ex Order 26.4(b)(1) coming from d ^{N b corder 25} were observed rder 26.4(b)(1). Actions taken ff were assigned to the unit; behaviors; ICCP updated; ks; and the resident was					
	at 1:30 PM, the U.S that the resident was NJ EX Order 26.4(b)(1) their N Ex order 26.4(b)(1) resident N Ex order 254 in the resident informer in their room. The completed several in resident's represent) and was allowed to hold WETOPERTY When asked did the heir room, the WETOPER stated that ed them that they had WETOPER FORM stated the facility had incident reports, called the tative, and they have called ause staff reported WETOPERTY (1)					
	at 2:08 PM, CNA #5 observed the resident the CNA had smelled resident's room. CN smelled **********************************	with the surveyor on 10/9/24 5 stated that she never ent VEX.0007.264(0)(1) in the facility, but ed NJ Ex. Order 26.4(b)(1) in the UA #5 stated that she often I reported it to the VEX.004(0)(0) 5 stated that certain residents heir NJ Ex.Order 26.4(b)(1), but if a x Order 26.4(b)(1) or an) who was caught VEX.0007.264(0) in NJ Ex.Order 26.4(b)(1) was kept at the nurse kept it in the VEX.0007.264(0) that the resident "probably"					

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		AND HUMAN SERVICES			FORM	APPROVED
	CONTRACTOR OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		. 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	l` '			PLETED
					(с
		315524	B. WING		10/	16/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER	MOUNT LAUREL, NJ 08054		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR		COMPLETION DATE
				DEFICIENCY)		
E 000		70				
F 689		-	F 68	39		
	never saw the resid	(1) in their possession, but she lent				
		ted that the resident was able				
	to NJ Ex Order 26.4	4b1				
	and took themselve	with a NJ Ex Order 26.4(b)(1) es ^{NJ Ex order 26.4(b)} She stated that the				
		s refused to ^{NJ Ex Order 26.4(b)(1)} .				
	_ , .					
		with the surveyor on 10/9/24 1 stated that she was familiar				
		habits and stated that				
	she guessed the re	sident <mark>NJ Ex Order 26.4(b)(1)</mark>				
		led it in the hallway." CNA #1 had also raised concerns				
		of NJ EX Order 26.4(b)(1) in the				
	hallway. When aske	ed if she had ever witnessed				
		in their room, CNA #1 yes." CNA #1 stated that a				
		go when she went into the				
	resident's room, sh	e saw the resident holding				
		nd. CNA #1 stated that she				
		irse but could not recall which it to. CNA #1 stated that the				
		he resident N ex order 26.4(9) in their				
	room, but nothing h					
		explained that the ^{N exorer 26.4(b)} sed to be kept at the front				
		e resident was ready to				
	, staff provid	led the resident with the				
		CNA #1 stated that the ^{CTCER 203(10)(1)} , but now the resident				
	just laid in the bed a					
	resident could NJEXOR					
	During a follow up i	nterview with the surveyor on				
		nterview with the surveyor on , Resident #144 stated that it				
	took one and a half	hours to get help NJ Ex Order 28.4(b)(1)				
	." When	asked if they ^{NJEx Order 26.4(b)(1} the				
	resident stated, ye	s, because ^{NJEx Order 28.4(b)(1)} get				

Facility ID: NJ03015

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	TIPLE CONSTRUCTION		(X3) DATE COMI	E SURVEY PLETED
		315524	B. WING _			(10/1	C 16/2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3718 CHURCH ROAD	DE		
LAUREL	UREL BROOK REHABILITATION AND HEALTHCARE CENTER MOUNT LAUREL, NJ 08054						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD	BE	(X5) COMPLETION DATE
F 689	The surveyor conduction was on the facility had done and the facility had done and the facility was re-educated or and relinquished the deficience on 10/9 was re-educated or and relinquished the surveyor conduction was placed.	t of the time I N Ex order 26.4(b)(1) that time, the resident pulled a bag to show the surveyor and he resident stated that the Ex Order 26.4(b)(1) on them ed NEX Order 26.4(b)(1) on them ed NEX Order 26.4(b)(1) on them ed NEX Order 26.4(b)(1) on them ed NEX Order 26.4(b)(1), but staff m out of bed regularly, so they NEX Order 26.4(b)(1), but staff m out of bed regularly, so they NEX Order 26.4(b)(1) in the at 5:00 AM (that morning). Acted a telephone interview on A, with the U.S. FOIA (b) (6) hat he had a problem with since they had been ent. The NEX Stated that the ckward." The NEX Stated that e everything to keep the NEX ORDER 26.4(b)(1) at he resident, and the facility etter with the NEX ORDER 26.4(b)(1)	F 68				

Facility ID: NJ03015

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPL	E CONSTRUCTION	1	E SURVEY
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .			PLETED
		315524	B. WING				C 16/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 78	F 6	89			
		erified the implementation of uring the continuation of the 0/10/24.					
	Part B.						
	identification of a ch status. This deficier	ailed to: complete a safe immediately upon the nange in resident's second nt practice was identified for 1 ident #191) reviewed for					
	This deficient practi following:	ice was evidenced by the					
	attempted to meet v not in their room. Li #10 was present ou and stated that the The surveyor went Resident #191 seat resident in the NJ = interviewed, the res hey had version and the they had version a per- that were	:44 PM, the surveyor with Resident #191 who was censed Practical Nurse (LPN) itside of the resident's room resident was NJ Ex Order 26.4(b)(1). to the Mexore 26.4(b)(1) and observed red at a table with another X Order 26.4(b)(1) . When ident stated that they only ben. Resident #191 stated that and NJ Ex Order 26.4(b)(1) and the surveyor the NEX ORDER 26.4(b) that ncil case and a MEX ORDER 26.4(b) e on the table in front of the ent stated that there was no					

Facility ID: NJ03015

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		315524	B. WING	<u> </u>			C 16/2024
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	S	IREET ADDRESS, CITY, STATE, ZIP CODE	10/	10/2024
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTE			R		18 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	NECOMERSION allowed ins resident stated that their NJ Ex Order 26.4(no NECOMERSION attenda of the observation. A review of Resider (an admission sum resident was admitt which included but y , NJ NJ Ex Order 26.4(b) A review of Resider Minimum Data Set dated NECOMERSION rev Interview for Mental out of 15, which ind NJ Ex Order 26.4(b)(J-Health Conditions coded as a "0" or "N A review of Resider identify Resident #1 A review of Resider at 3:45 PM NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/Readmis NECOMERSION/READMISSION/Readmis NECOMERSION/READMISSION/REA	side of the facility. The he/she was allowed to keep (1) in their room. There was ant in the courtyard at the time ht #191's Admission Record mary), revealed that the ed to the facility with diagnosis were not limited to; ^{NJEX ORDER204(0)(1)} (EX Order 26.4(b)(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	F 68	89			

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		AND HUMAN SERVI					FORM	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	(CLIA (X2)		E CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED	
		315524	B. V	B. WING				; 6/2024	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE,	ZIP CODE			
LAUREL	BROOK REHABILITA	ATION AND HEALTHCA	RE CENTER	TER 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		id Prefix Tag	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD	BE	(X5) COMPLETION DATE	
F 689	health record (EHR surveyor and stated resident. LPN #10 s needed a vertice of were safe to vertice of surveyor observed that was completed surveyor inquiry, we resident currently review of the assess resident was safe to in an vertice equipment such as , or NJ Ex Order 26.4(and safely secure a room. On 10/10/24 at 10:2 Resident #191 seat When interviewed, told me yesterday to vertice of the resident stated the resident a vertice told to follow the rul resident further stated to borrow vertice of the resident meeded to vertice of the same to borrow vertice of the resident meeded to	b) in the presence of the d that she did not see if h was completed for the stated that Resident # evaluation to see if he main a second second for the stated that Resident # evaluation to see if he main a state for the second second second for the detailed, "Does the lex order 26.4(b)(1)? Metoder and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.	that a e 191 /she the luation / after e Further he further he s able y policy, h their oserved dside. man b have e toilet." d given , "I was The at I could at that bermitted a hen the	F 689					
FORM CMS-25	567(02-99) Previous Versions	-	nt ID: UBXH11	Fac	cility ID: NJ03015	If continuation	n sheet Pa	age 81 of 171	

		AND HUMAN SERVICES				FORM	APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPL	LE CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			IPLETED C
		315524	B. WING				
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL BROOK REHABILITATION AND HEALTHCARE CENT			R		MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	at 10:45 AM, the U.) stated that nursing did a smoki screening process. admission to the fac deemed to be WEXO day or two, was ide USTRANOTO stated that identified when the when he/she was in USTRANOTO stated that that the resident was The USTRANOTO stated a NJ Ex Order 26.4 The USTRANOTO stated was necessary to d safe to USTRANOTO stated manage NJ Ex Order 26.4 Net order for a USTRANOTO stated Net of the admission not suppose of a USTRANOTO if the resident was that the residen	S. FOIA (b) (6) It upon admission to the facility ing assessment as part of the The USFORTON stated that upon cility Resident #191 was ruer264(b)(1) and within the past ntified as UECOURT 264(b)(1). The she did not know who resident started UECOURT 264(b)(1) The it was brought to our attention as going outside and UECOURT 264(b)(1) that the resident may only use (b)(1) UECOURT 264(b)(1) were not permitted. that a UECOURT 264(b)(1) assessment etermine if a resident were with the surveyor on 10/15/24	F 6	89			

Facility ID: NJ03015

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES	(Y2) MULT			MB NO. 0938-0391 (X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	1 ° '				PLETED
						0	0
		315524	B. WING			10/1	16/2024
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER				OUNT LAUREL, NJ 08054		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
	1		,		DEFICIENCY)		
F 689	Continued From pa	ae 82	F 68	20			
	Continued i rom pu	ge 02	1.00	5			
		ity policy, "Smoking					
	Policy-Residents" d revealed the followi	ated revised October 2023					
		ng.					
		ablished and maintains safe					
	resident smoking p	ractices.					
	Prior to, and upon a	admission, residents are					
		lity smoking policy, including					
		g areas, and the extent to n accommodate their smoking					
	or non-smoking pre						
	Smoking is only per	rmitted in designated smoking					
	areas, which are loo	cated outside of the building.					
		wed inside the facility under					
	any circumstances.						
		g status is evaluated upon					
		oker, the evaluation includes: acco consumption; method of					
		on (traditional cigarettes;					
	electronic cigarettes						
		ing; and ability to smoke safety ervision (per a completed Safe					
	Smoking Evaluation						
	The staff conculte w	vith the attending physician					
		nursing services (DNS) to					
	determine if safety i	restrictions need to be placed					
	on a resident's smo Safe Smoking Eval	king privileges based on the					
	C C						
		o smoke safely is re-evaluated					
		gnificant change (physical or etermined by the staff.					
	- /	-					
	Resident's who ha	ave independent smoking					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/31/2025 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l • • •	PLE CONSTRUCTION	Сом	E SURVEY PLETED
		315524	B. WING			C 16/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	privileges are permi electronic-cigarettes smoking items in th disposable safety lig forms of lighters, in prohibited. Residents are not p items to other reside N.J.A.C 8:39-31.6(e Bowel/Bladder Inco CFR(s): 483.25(e)(1) §483.25(e) Incontin §483.25(e)(1) The f resident who is com admission receives maintain continence condition is or beco not possible to main §483.25(e)(2)For a incontinence, based comprehensive ass ensure that- (i) A resident who et indwelling catheter resident's clinical co catheterization was (ii) A resident who et indwelling catheter is assessed for rem as possible unless f demonstrates that o and (iii) A resident who is	 itted to keep cigarettes, s, pipes, tobacco, and other eir possession. Only ghters are permitted. All other cluding matches, are ermitted to give smoking ents e) ntinence, Catheter, UTI 1)-(3) ence. facility must ensure that tinent of bladder and bowel on services and assistance to e unless his or her clinical mes such that continence is ntain. resident with urinary d on the resident's essment, the facility must nters the facility without an is not catheterized unless the ondition demonstrates that 	F 68			11/21/24

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR CENTERS FOR MEDICARE & MEDICAID SERVICES OMB N								
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	IPLE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	NG	COMPLETED				
	315524	B. WING _		10/16/2024				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		٦			
LAUREL BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054					
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	N			
Continence to the ex- §483.25(e)(3) For a incontinence, based comprehensive ass ensure that a reside receives appropriat restore as much no possible. This REQUIREMEN by: Based on observat and review of pertin determined that the NJ Ex Order 26.4(b) ordered by the physe (Resident #174 and This deficient practific following: 1.) On 10/8/24 at 11 observed Resident with a NJ Ex Order Secure NJ Ex Order 26.4(b) This deficient practific following: 1.) On 10/8/24 at 11 observed Resident with a NJ Ex Order Secure NJ Ex Order 26.4(b) This deficient practific following: 1.) On 10/8/24 at 12 observed Resident with a NJ Ex Order NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)	the infections and to restore extent possible. a resident with fecal d on the resident's sessment, the facility must ent who is incontinent of bowel e treatment and services to armal bowel function as NT is not met as evidenced tion, interview, record review, hent facility documents, it was e facility failed to a.) ensure an D(1) and a the floor and b.) ensure the D(1) was changed as sician for 2 of 2 residents d #188) reviewed for Mercourter ice was evidenced by the 1:27 AM, the surveyor #188 sitting in a wheelchair 20.4(b)(1) ed to the wheelchair. The ouching the floor. B AM, the surveyor observed and a wheelchair with a D(1) secured to the D(1) secured to the D(1) secured to the D(1) secured to the D(1) secured to the	F 69		ined urinary ats with ducted bag vsician g were ere clinical ary ed as date ot hose e audit hary ed by bags				

Event ID: UBXH11

Facility ID: NJ03015

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	RS FOR MEDICARE	& MEDICAID SERVICES	-		OMB NO.	0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	СОМ	E SURVEY PLETED
		315524	B. WING			C 16/2024
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP		
AUREL	. BROOK REHABILITA	TION AND HEALTHCARE CENT	ER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 690	On 10/10/24 at 10:2 Resident #188 sittir NJ Ex Order 26.4(b) wheelchair. The NE NJ Ex Order 26.4(b)(1) to the floor. The surveyor NJ Ex Order 26.4(b)(1) was or indicated the NJ Ex Order NJ Ex Order 26.4(b)(1) was or indicated the NJ Ex Order According to the Ad summary), Residen included, but were n and NJ Ex Review of the admi (MDS), an assessm management of car resident had a Brief score of 'NET which cognition was NJ Ex review of the MDS i NJ Ex Order 26.4(b)(1). Review of the Indivi Plan (ICCP) include "I have an NJ Ex Order NJ Ex Order 26.4(b)(1)," w N Ex Order 26.4(b)(1) and W include an intervent NJ Ex Order 26.4(b)(1) and W include an intervent NJ Ex Order 26.4(b)(1) and W include an intervent NJ Ex Order 26.4(b)(1) shoul Review of the Order NJ Ex Order 26.4(b)(1) shoul	24 AM, the surveyor observed ag in a wheelchair with a (1) secured to the secured to the that connected the also observed that the lated 3.511," which ar 26.40(1) was last changed on PM to 11:00 PM shift. Imission Record (admission at #188 had diagnoses which not limited to, NUECONCE 20.40(1) Order 26.4(b)(1). Ssion Minimum Data Set hent tool used to facilitate the re, dated 1.5000000000000000000000000000000000000		Variances will be addresse will be conducted weekly x monthly x 2 months. The f audits will be submitted by Nursing to the QAPI Comr and recommendation mon months or ongoing until co sustained	4 weeks, then indings of the the Director of nittee for review thly for 3	

DEPAR	FORM	APPROVED					
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '		E CONSTRUCTION		E SURVEY PLETED
				-		(c
		315524	B. WING			10/	16/2024
NAME OF I	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		OUNT LAUREL, NJ 08054		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
					DEFICIENCY)		
E 600		00					
F 690		ge 80 ^{der 26.4(b)(1)} Treatment	F 69	90			
		ord (TAR) included the					
	aforementioned ord	ler was signed out as					
		and signed out as not ne resident being out of the					
	facility on NEXOTOR 25.4	le resident being out of the					
		ress Notes, dated ^{NECORE 254(0)(} lid not include a rationale for					
		r 26.4(b)(1) was not changed					
	on NJ EX Order 26.4() or that t	he resident was out of the					
	facility on Nexotleration.						
	During an interview	with the surveyor on 10/10/24					
	at 10:43 AM, Certifi	ed Nursing Assistant (CNA)					
	#3 stated NJ Ex Or	der 26.4(b)(1) and and buch the floor for infection					
	control reasons. At						
	accompanied the si	urveyor to Resident #188's					
		edged the <mark>NJ Ex Order 26.4(b)(1)</mark>					
		g the floor. The CNA then ecured the ^{NJ Ex order 26.4(b)(1)} to the					
	wheelchair so that t	he NJ Ex Order 26.4(b)(1) and NJ Ex Order 26					
	were not touching t	he floor.					
	During an interview	with the surveyor on 10/10/24					
	at 10:51 AM, Licens	sed Practical Nurse (LPN) # 5					
	stated NJ Ex Order						
		sanitary reasons. The LPN ^{Ex Order 26:4(b)(1)} should be					
		the risk of infection.					
	During on interview	with the survey of $10/10/24$					
	at 11:02 AM, the	with the surveyor on 10/10/24 S. FOIA (b) (6)					
	stated that	tNJ Ex Order 26.4(b)(1)					
		should not touch the floor for					
	that NJ Ex Order 26.4(b)(1)	. The ^{USTOMD(0)} further stated should also be changed as					
		sician for infection prevention.					

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT			MB NO. 0938-0391 (X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		315524	B. WING _				C 16/2024
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		18 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	At that time, the sur #188's WEX order 204(0) USFOAD(0) verified that was ordered to be of accompanied the sur The USFOAD(0) acknow was last changed o should not have sig on WEXCOMPT acknow was last changed o should not have sig on WEXCOMPT acknow was last changed o should not have sig on WEXCOMPT acknow treatment order to b shift. The USFOAD(0) s accurately document record to maintain of During an interview at 1:10 PM, the USS NJ EX Order 26.4(b) not touch the floor f The USFOAD further st the physician's order NUEX Order 26.4(b)(1) and with the date it was stated that it was im document on the TA completed. 2.) On 10/8/24 at 10 the surveyor obserview bed with his/her eye and W	Veyor reviewed Resident TAR with the US FOX(0)(1) The t the resident's ^{NJ} Ex Order 26.4(0)(1) changed weekly and urveyor to the resident's room. Wedged that the NJ Ex Order 26.4(0)(1) n VEX CONCERNENT and that the nurse ned the order as completed FOX(0)(2) further stated that on a should have rescheduled the be completed on the following stated that it was important to nt in the resident's medical continuity of care. with the surveyor on 10/10/24 FOIA (b) (6) (b) (c) (c) (c) (c) (c) (c) FOIA (b) (6) (c)	F 69	90			
	On the same day at	t 10:42 AM, the surveyor					

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DEPART	FORM	APPROVED					
		& MEDICAID SERVICES				OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			COM	IPLETED
		315524	B. WING _				C 16/2024
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		718 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
F 690	Continued From pa	ge 88	F 69	90			
	accompanied the Li	icensed Practical Nurse Unit) #1 to Resident #174's room					
		ngs. LPN/UM #1 picked the) off the floor and ^{NJ Ex Order 26.4b1}					
		nission Record (admission					
		that the resident was oses, which included but were					
	not limited to; NJ Ex	Corder 26.4(b)(1), NU Ex Order 2					
	, <mark>NJ Ex (</mark>	Order 26.4(b)(1), and ^{NJ Ex order 26.4(b)}					
		nission comprehensive (MDS), an assessment tool					
	dated NJ Ex Order 25.4(), inclu	ided the resident had a Brief					
		l Status score of 'Mexor which ent's cognition was Wexore read					
	Further resident had an NJ E	eview of the MDS included the x Order 26.4(b)(1)					
		vidualized Comprehensive ncluded a focus area, created					
	NJ EX Order 26.4(), for NJ EX Ord	der 26.4(b)(1) related to NUEX Order 25.4					
	Interventi	on included: to provide shift and as needed. The					
	ICCP did not include	e an intervention to keep the					
	A review of the phys "Catheter Care even	sician's orders included, ry shift."					
	at 10:50 AM, LPN/L	with the surveyor on 10/10/24 JM #1 stated the ^{Nexoderactor} ich the floor and that they					
	usually used the un	derframe of the bed to keep it					
		JM #1 stated, when the e on the unit, we always					
		LPN/UM #1 further					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/31/2025 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ST CONNECTION	DEMINIOR NORMOLER.	A. BUILDIN	IG		C
		315524	B. WING		10/	16/2024
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 690 F 692 SS=D	stated if they refuse they have Mexorerative the wheelchair so it LPN/UM #1 stated in NJ Ex Order 26.4(b) floor for infection co prevent the Mexorerative prevent the Mexorerative policy, revised 08/2 catheter tubing and floor." Further revise to change the drain physician. NJAC 8:39 - 27.1(a Nutrition/Hydration CFR(s): 483.25(g)(1) §483.25(g) Assisted (Includes naso-gast both percutaneous percutaneous endo enteral fluids). Bas comprehensive ass ensure that a reside §483.25(g)(1) Main of nutritional status, desirable body weig balance, unless the demonstrates that t preferences indicate	 the Network of the stored underneath does not get in their way." it was important to keep the O(1) and Network off the portrol purposes, dignity, and rom getting Network off the drainage bag are kept off the drainage bag are kept off the ew of the policy did not include age bag as ordered by the) Status Maintenance 1)-(3) d nutrition and hydration. tric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's sessment, the facility must ent- tains acceptable parameters , such as usual body weight or ght range and electrolyte resident's clinical condition this is not possible or resident e otherwise; ered sufficient fluid intake to 	F 69	20		11/21/24

Facility ID: NJ03015

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM, CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO.						
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING		
		315524	B. WING		(10/1	C 16/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER I	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	there is a nutritional provider orders a th This REQUIREMEN by: Based on observat and review of pertin determined that the NECOTORIZON (D) (a) according to the factorist U.S. FOIA (b) (6) according to the factorist U.S. FOIA (b) (6) according to the factorist U.S. FOIA (b) (6) according to the factorist (Residents (Resident VECOTORIZON) This deficient practic following: 1.) On 10/11/24 at 1 observed Resident which included a NJ label. According to resident was support The surveyor took a 12:35 PM, the U.S. NECOTORIST (D) 10/15/24 at 12:3 Resident #91's lunctorist serving of NECOTORIST (C) 10/15/24 at 12:3 Resident #91's lunctorist serving of NECOTORIST (C) 10/15/24 at 12:3 Resident #91's lunctorist serving of NECOTORIST (C) 10/15/24 at 12:3 Resident was support According to the resident was support (C) 10/15/24 at 12:3 Resident #91's lunct (C) 10/15/24 at 12	ered a therapeutic diet when problem and the health care erapeutic diet. NT is not met as evidenced ion, interviews, record review, ent facility documents, it was facility failed to a.) provide escribed by the physician, b.) as recommended by the , and c.) obtain source for 2 of 5 #91 and #7) reviewed for ce was evidenced by the 2:12 PM, the surveyor #91 receive his/her lunch tray Ex Order 26.4(b)(1) without a the resident's meal ticket, the sed to receive Source of the lunch tray. At FOIA (b) (6) sident who stated he/she at the Source of the surveyor observed the tray which included a backaged by the facility. sident's meal ticket, the	F 692		ensed of ed Vith ted per valized ential to vith leted to nt with iewed s were lucated lents o uld be ursing ly ntly cy.	

Facility ID: NJ03015

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315524	B. WING			C 10/16/2024		
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ir		718 CHURCH ROAD IOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 692	Continued From pa	ige 91	F 6	92				
	summary, Resident included, but were n Review of the quart (MDS), an assessm management of car resident had a Brief score of """" which cognition was """"" included the resident included the resident in the last mo six months and was physician-prescribe Review of the Indivi Plan (ICCP) include that the resident ha to """"""""""""""""""""""""""""""""""""	and ^{NECONDET204(0)(1)} terly Minimum Data Set ment tool used to facilitate the re, dated ^{NECONDET20} , included the f Interview for Mental Status indicated the resident's Further review of the MDS in had a ^{NECONDET204(0)(1)} of ^{NECONDET2} in the last			the 2567. 4. The RD/designee will complete audit of 3 residents with orders for foods to validate provision per clini provider orders. In addition, the RD review 3 residents with weekly weig orders to validate weights taken per clinical provider orders and re-weig completed as indicated based on far policy. Variances will be addressed These audits will be conducted weights weeks, then monthly x 2 months. The findings of the audits will be submit the Director of Nursing to the QAP Committee for review and recommendation monthly for 3 mo ongoing until compliance is sustain	fortified cal) will ght r hs acility ekly x 4 he ted by nths or		
	Review of the Orde	ntion for ' <mark>NJ Ex Order 26.4(b)(1)</mark> : d Dinner,'' revised <mark>N Ex order 26.4(</mark> r Summary Report, as of a physician's order for						
	NJ Ex Order 26.4(b)(1) W ordered W Ex Order 26.4(vith Lunch and Dinner,"						
	dated ^{NJ EX Order 25.4} includ NJ EX Order 26.4(b)(1) twi	terly ^{NECORECTION} Assessment, led the resident was on ice a day which provided ^{NECO} id <mark>NJ Ex Order 26.4(b)(1)</mark> .						
	at 1:49 PM, the U.S	with the surveyor on 10/15/24 5. FOIA (b) (6) (1) (1) (1) (26.4(b)(1) (

	FORM	APPROVED					
	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT		E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	1 ° '		ECONSTRUCTION		PLETED
				-		(c
		315524	B. WING			10/	16/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		718 CHURCH ROAD		
				M	OUNT LAUREL, NJ 08054		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
				_	DEFICIENCY)		
F 692	Continued From pa	ae 92	F 69	22			
1 002	-	wasn't any ^{NJ Ex Order 26.4(b)(1)}	FO	2			
		ding. At that time, the					
		the pictures of					
	Resident #91's lunc	ch trays on 10/11/24 and					
		For confirmed that WEX ORE 725.4() ven to the resident. The U.S. Form					
		as unsure why we come as					
	was not pro	ovided for the resident. The					
	U.S. FOIA explained that	a U.S. FOIA (b) (6) Was					
		cking the residents' meal trays					
		4(0)(1) were included on the The stated that if					
	NJ Ex Order 26.4(b)(1) Wa	is not available, he would					
	either increase the	amount of NEX OTHER 25.4(0) on the tray					
		())()) for recommendations.					
		with the surveyor on 10/15/24					
		FOIA (b) (6) responsible for					
		trays stated there wasn't any provide to the residents on					
		4 but was not sure why.					
		with the surveyor on 10/15/24					
	at 2:08 PM, the U.S						
		o ensure designated residents (()(1) on their meal trays.					
	When asked how th	ne ^{us} knows whether the					
	pudding on the resident	dent's tray is ^{N Ex order 25.40} or not,					
		st assumes that the ^{NJ Exorder 25.4(b)}					
		if the meal ticket indicated ne wife further stated he had					
		at the kitchen was unable to					
		4(b)(1) on 10/11/24 and					
	10/15/24, and if he	had been notified, he would					
		w interventions for residents					
		until it was available again. the kitchen staff should not					
		intervention, but should					
		when NJ Ex Order 26.4(b)(1) are not					

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES O								
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY				
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		PLETED			
		315524	B. WING _						
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD					
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	MOUNT LAUREL, NJ 08054					
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION			
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE			
F 692	Continued From paravailable. During an interview at 4:16 PM, in the p the U.S. FOIA (b) (f or a reason been provided to Ro Review of the Mexicon Roster, dated Roster, dated Roster, dated Roster, dat	ge 93 with the surveyor on 10/15/24 resence of the survey team,)) stated the substitute should have esident #91. (Special revealed there were 30 ility who were supposed to (00) at lunch. ry's Special Nutrition Program 8/22, included, "The Special SNP) is a fortified food d provide for the increased ents of residents who are pressure injuries, experiencing iss, have poor intake and/or "Further review of the policy at the facility should do if unavailable. 12:37 PM, the surveyor #91 lying in bed. The y was on the bedside table for the NECOMMENDING. At the food and had enough mission Record, an admission #91 had diagnoses which	F 69						
		anu							

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES O							
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		315524	B. WING _			C 16/2024		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
F 692	Review of the quart (MDS), an assessm management of car resident had a Brief score of 'NET' which NJ EX Order 26.4(b)(1) included the resider in the last mo six months and was physician-prescribe Review of the Care N EXCORPTS Review of the Care in that the resident related to N with N EXCORPTS Assessment, writter) and dated N EX Order 26.4(experienced a N Ex O had a NJ EX Order 26.4(experienced a N Ex O for weekly N EX Order 26.4(in the resident's N EX Order 26.4(in the resident's N EX Order 26.4(N EX Ord	erly Minimum Data Set nent tool used to facilitate the re, dated Meroder20, included the Interview for Mental Status indicated the resident's . Further review of the MDS In thad a Meroder204(b)(1) of the last in the la	F 69	2				

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES O							
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING			PLETED	
		315524	B. WING				C 16/2024	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		8718 CHURCH ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 692	at 12:40 PM, Certifi #4 stated that residualless the nurse not frequent stated that residualless the nurse not frequent are document then the nurse enter During an interview at 12:46 PM, Licens stated residents we stated in the stated to in the stated the resident's EMR. W adequately monitor experienced a NJ E stated, "to determin "." During an interview at 12:54 PM, Licens Manager (LPN/UM) Net correction are written that states of the state of the when asked about Net correction the paper copies of the When asked about Net correction the the the LPN/UM review verified the weekly and that she could the have been done if t "prevent NJ Ex Order	with the surveyor on 10/15/24 ed Nursing Assistant (CNA) ents are "Forestand" monthly dified the CNA of more The CNA further stated that ented in a Nerostand book and rs the "Forestand" monthly unless the more frequent "Forestand" The that "Forestand" were documented and then entered into the hen asked the importance of ing "Forestand" for a resident who x Order 26.4(b)(1), the LPN e the cause of the "Forestand" with the surveyor on 10/15/24 sed Practical Nurse/Unit #3 stated residents were aless otherwise instructed by . The LPN/UM further stated tten in the "Forestand" book, residents' EMR, and then the "Forestand" were shredded. Resident #91's weekly ecommended in "Forestand" were not completed not find a discontinued r the weekly "Forestand" should he "Forestand" recommended it to	F 6	92				

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 AND PLAN OF CORRECTION (X) PAULINE CONSTRUCTION (X) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X) PAULINE CONSTRUCTION (X) MULTIPLE CONSTRUCTION NAME OF PROVIDER OR SUPPLER 315524 B. WING LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER 3716 CHURCH ROAD MUID EACH OF CREATED TO DEFICIENCIES 3718 CHURCH ROAD MUID EACH OF CREATED Y DEFICIENCIES D. MONT LAUREL, NJ 08054 MUID EACH OF CREATED Y DEFICIENCIES D. MONT LAUREL, NJ 08054 MUID EACH OF CREATED Y DEFICIENCIES D. MONT LAUREL, NJ 08054 MUID EACH OF CREATED Y OR LSC DENTIFYING INFORMATION) PERK PROVIDER CON SHOULD BE PREEX EACH OF CREATED Y OR LSC DENTIFYING INFORMATION) PROVE PROVIDER CON SHOULD BE PREEX EACH OF CREATED Y OR LSC DENTIFYING INFORMATION) PROVE PROVIDER CON SHOULD BE If 1:01 PM, the "stated that the veckly lateration and then review the completed about Resident #71's weekly lateration of the resident's for Based about Resident #71's weekly lateration of the resident's EMR. F 692 During an interview with the surveyor on 10/15/24 at 11:53 AM, the surveyor observed Resident #77's Admission Record, an admission summary, revealed that the resident tate and the take that the resident tate and theathe			AND HUMAN SERVICES				FORM	APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING C C 315524 B. WING C 10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD PRETIX (EACH ORDERS) FLAN OF CORRECTION (EACH ORDERS) FLAN OF CORRECTION (EACH ORDERS) FLAN OF CORRECTION PRETIX (EACH ORDERS) FLAN OF CORRECTION (EACH ORDERS) FLAN OF CORRECTION (EACH ORDERS) FLAN OF CORRECTION PRETIX (EACH ORDERS) FLAN OF CORRECTION (EACH ORDERS) FLAN OF CORRECTION (EACH ORDERS) FLAN OF CORRECTION PRETIX (EACH ORDERS) FLAN OF CORRECTION (EACH ORDERS) FLAN OF CORRECTION (EACH ORDERS) FLAN OF CORRECTION PRETIX (EACH ORDERS) FLAN OF CORRECTION (EACH ORDERS) FLAN OF CORRECTION (EACH ORDERS) FLAN OF CORRECTION TAG Stated that if weekly MEMORY (EACH ORDERS) FLAN OF CORRECTION (EACH ORDERS) FLAN OF CORRECTION TAG Stated that if weekly MEMORY (EACH ORDERS) FLAN OF CORRECTION (EACH ORDERS) FLAN OF CORRECTION TAG Stated that the weekly MEMORY (EACH ORDERS) FLAN OF CORRECTION (EACH ORDERS) FLAN OF CORRECTION <								
10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE MAIN ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WAS TE PRECEDE DB FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PRECIX TAG PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY WAS TE PRECEDED BO FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PRECIX TAG PROVIDERS PLAN OF CORRECTION MC COMPLETION (EACH DEFICIENCY WAS TE PRECEDED BO FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PRECIX TAG PROVIDERS PLAN OF CORRECTION MC COMPLETION (EACH DEFICIENCY WAS TE PRECEDED BO FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PRECIX TAG PREFIX (EACH DEFICIENCY WAS TO PROVIDE BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 692 Continued From page 96 at 1:01 PM, the iff stated that if weekly iff for it the resident's EMR. When asked about Resident #91's weekly iff for it the resident's EMR. F 692 J During an interview with the surveyor on 10/15/24 at 4:18 PM, in the presence of the survey team, the ISS.FOLK (0)/(6) stated Resident #91's weekly iff iff iff iff iff iff iff iff iff if				· · ·			COM	PLETED
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 (M) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PRETX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PRETX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PRETX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 000 F 692 Continued From page 96 at 1:01 PM, the iff stated that if weekly information are recommended, the iff will obtain a physician's order and then review the completed about Resident #01's weekly information should have been obtained based on the resident's EMR. F 692 During an interview with the survey ream, the USE FOIA (b) (0) (0) (0) (0) (0) (0) (0) (0) (0) (0)			315524	B. WING				
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER MOUNT LAUREL, NJ 08054 (x) (p) PREFIX SUMMARY STATEMENT OF DEFICENCES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (x) PREFIX (cACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x) DATE F 692 Continued From page 96 at 1:01 PM, the Twi stated that if weekly incoment are recommended, the Twi will obtain a physician's order and then review the completed interest of the stated that the weekly incoment should have been obtained based on the recommendation and then entered into the resident's EMR. F 692 During an interview with the surveyor on 10/15/24 at 1:15 FOIA (b) (G) stated Resident #7) Should have been obtained based on the recommendation and then entered into the resident's EMR. stated Resident #91's weekly interest should have been obtained based on the recommendation and then entered into the resident's EMR. stated Resident #91's weekly interest should have been obtained based on the recommendation and then entered into the resident's EMR. stated Resident #91's weekly interest should have been completed as recommended by the Twi At 1:53 AM, the surveyor observed Resident #7 lying in bed with a meal tray in front of him/her that was unbuched. The resident stated that he/she had Interestion A review of Resident #7's Admission Record, an A review of Resident #7's Admission Record, an	NAME OF F	PROVIDER OR SUPPLIER						
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Coultivition DATE F 692 Continued From page 96 at 1:01 PM, the stated that if weekly stores are are recommended, the stated that if weekly stores are are recommended, the will obtain a physician's order and then review the completed should have been obtained based on the recommendation and then entered into the resident's EMR. F 692 During an interview with the survey team, the U.S. FOIA (b) (c) should have been obtained based on the resident's EMR. Stated Resident #91's weekly should have been completed as recommended by the state desident #91's weekly the state desident #91's weekly the state desident #91's weekly the stated that the weekly team, the U.S. FOIA (b) (c) should have been completed as recommended by the stated that he/she had traves of the survey conserved Resident that was unbuched. The resident stated that he/she had the survey of the stated that he/she had the stated that the veekly team at the veekly team at the stated that he/she had the stated that the veekly team at the stated that the veekly team at the stated that the veekly team at the veekly team at the stated that the veekly team at the stated that the veekly team at the stated team at the stated that team at the stated that the veekly t	LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R				
at 1:01 PM, the Test stated that if weekly the completed are recommended, the Test will obtain a physician's order and then review the completed Understain in the resident's EMR. When asked about Resident #91's weekly the test of the completed The Test stated that the weekly the test of the completed The Test stated that the weekly the test of the completed The Test stated that the weekly the test of the completed The Test stated that the weekly the test of the completed The Test stated that the weekly test of the completed The Test stated that the weekly test of the completed of the completed based on the recommendation and then entered into the resident's EMR. During an interview with the survey or on 10/15/24 at 4:16 PM, in the presence of the survey team, the US.FOIA (b) (6) the stated Resident #91's weekly the test of the survey of the survey team, the US.FOIA (b) (6) the test of test of the test of	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	¢	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
was admitted to the facility with diagnosis which included, but were not limited to, NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1) A review of Resident #7's quarterly Minimum Data Set (MDS), an assessment tool, dated NEX ORDER 2000 revealed that the resident had a Brief Interview for Mental Status score of NET out 15, which indicated that the resident was NEX Order 26.4(b)(1) Further review of the MDS under Section	F 692	at 1:01 PM, the series are recommended, physician's order ar are recommended. The resident source are recommended in the resident's order are resident's the series should have been or recommendation are resident's EMR. During an interview at 4:16 PM, in the pethe U.S. FOIA (b) (6 #91's weekly become as recompleted as re	stated that if weekly veromerzealt the will obtain a and then review the completed ent's EMR. When asked 's weekly veromerzealt for verom d that the weekly veromerzealt obtained based on the add then entered into the with the surveyor on 10/15/24 presence of the survey team, a) stated Resident should have been mmended by the verom table of the facility on 10/8/24 inveyor observed Resident #7 meal tray in front of him/her I. The resident stated that with the resident stated that tour of the facility on 10/8/24 inveyor observed Resident #7 meal tray in front of him/her I. The resident stated that tour of the facility or to fim/her I. The resident stated that tour of the facility or to fim/her I. The resident stated that tour of the facility or for the facility of the stated that the resident efacility with diagnosis which not limited to, NJ Ex order 26.4(b)(1) co.4(b)(1)), and b)(1) .	F 69	92			

Facility ID: NJ03015

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		AND HUMAN SERVICES				FOF	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPL	E CONSTRUCTION	(X3) D	ATE SURVEY
AND PLAN C	of correction	IDENTIFICATION NUMBER.	A. BUILDI	NG			C
		315524	B. WING			1	0/16/2024
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		NOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 692	NJ Ex Order 26.4(b) resident had a N Ex ord last month or NJ Ex ord and was not on a pl NJ Ex Order 26.4(b)(1) A review of Resider Comprehensive Ca entry with a revision of: "I have a NJ Ex Or NJ Ex Order 26.4(b) I will N Ex Order 26.4(b) I n the presence of g) is only increasing NJ Ex Order 26.4(b) I meals and NJ Ex Order (Plan of Care) 2. Mo N Ex Order 26.4(b) I Note, date	(1) reflected that the der 26.4(b)(1) of ^{NJ Ex order 26.4(b)(1)} in the der 26.4(b)(1) in the last six months hysician-prescribed). ht #7's Individualized re Plan (ICCP) revealed an h date of ^{N Ex order 26.4(} , and a focus rder 26.4(b)(1) r/t (related to)	F 6	92			

Facility ID: NJ03015

If continuation sheet Page 98 of 171

		AND HUMAN SERVICES					FORM	APPROVED
		& MEDICAID SERVICES						0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION	(сом	E SURVEY PLETED
		315524	B. WING				(10/1) 16/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		718 CHURCH ROAD IOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	c	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD E		(X5) COMPLETION DATE
F 692	N Exorder 2540% and N Exorder 2540% and N Exorder 2540% and N Exorder 264(b)(1 Was address an NJ Ex Order 26.4(b)(1 Was address an NJ Ex Order 26.4(c) The surveyor review under the N Exorder 2640 - On N Exorder 2640 the ress - On N Exorder 2640 the	t NJ Ex Order 26.4(b)(1) and cumented NJ Ex Order 26.4(b)(1) and a NJ Ex Order 26.4(b)(1) seed. RD #2 documented that b)(1) was pending. wed Resident #7's NJ Ex Order 26.4(b)(1) esident NJ Ex Order 26.4(b)(1) recorded in NJ Ex Order 26.4(b)(1) fieldent NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) sident NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) sident NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) with the surveyor on 10/09/24 and NJ Ex Order 26.4(b)(1) with the surveyor on 10/09/24 and Practical Nurse/Unit and the residents together and orded in the EHR. LPN/UM #1 s were NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)	F 6	92				
	admission, then we monthly thereafter u	ekly for four weeks, then						

		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED
		& MEDICAID SERVICES			O		0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	IPLE CONSTRUCTION		СОМ	E SURVEY PLETED
		315524	B. WING			(10/1	6/2024
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT			
LAUREL	. BROOK REHABILITA	TION AND HEALTHCARE CENTE	IR	3718 CHURCH ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPE DEFICIENCY)	BE	(X5) Completion Date
F 692	informed the nursin required. LPN/UM # get missedand the always the best." On 10/10/24 at 12:2 Resident #7 lying in front of him/her that resident stated that During an interview 1:00 PM, RD #1 stat the first of the mont the month. He state or Stated that the first of the mont the month. He state was requested. RD requests in a book with the U.S. FOIA (b) questioned Resider He stated that the r NECORCECCO (00) and was at the r stated that it was not the resident NECORCECCO stated that he did n did a NECORCECCO (00) At that time, RD #1 be documented in the NJ Ex Order 26.4(b) months. The survey between NECORCECCO and At that time, RD #1 be documented in the NJ Ex Order 26.4(b) months. The survey between NECORCECCO and NECORCECCO NECORCE	g staff when a Wereder 204000 was #1 stated, "Sometimes Were 204000 bed with their meal tray in t was Wereder 204000 today. With surveyor on 10/10/24 at the d that Were due by the fifth of ed that if a Were done on th and were due by the fifth of ed that if a Were 204000 was noted, a repeat Were 204000 was noted, a repeat Were 204000 #1 stated that he put the on the unit and communicated (9). RD #1 stated that he nt #7's NJ Ex Order 204000 #1 stated that he put the on the unit and communicated (9). RD #1 stated that he nt #7's NJ Ex Order 204000 was noted, a repeat Were 204000 #1 stated that he put the on the unit and communicated (9). RD #1 stated that he nt #7's NJ Ex Order 204000 was noted, a repeat Were 204000 was noted was Were 2040000 was noted was Were 2040000 was noted was Were 20400000 was noted was Were 20400000 was noted was Were 20400000000000000000000000000000000000	F 69	12			

		AND HUMAN SERVICES			FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		PLETED
		315524	B. WING			_ 16/2024
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	. BROOK REHABILITA	TION AND HEALTHCARE CENTE	IR	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 692	appear that it was of resident's Wetomerzet in documented eviden NEXOTER 204(0)(1) in NJ EXOTER was not documented . Further review documented Wetomerzet resident had a docu , and a Wetomerzet resident had a docu , and a Wetomerzet of NJ EXOTER 204(0)(1) and documented on Weto initial monthly Wetomerzet with no documented During an interview at 11:02 AM, the U. that the U.S. FOIA(0)(2) fol NJ EXOTER 204(0)(1) but typic would trigger a Wetomerzet U.S. FOIA(0)(6) reported then noted notified the U.S. FOIA(0)(1) the NJ EXOTER 204(0)(1) but typic would trigger a Wetomerzet U.S. FOIA(0)(6) reported then noted notified the U.S. FOIA(0)(1) the NJ EXOTER 204(0)(1) but typic would trigger a Wetomerzet U.S. FOIA(0)(6) reported then noted notified the U.S. FOIA(0)(1) the NJ EXOTER 204(0)(1) but typic would trigger a NJ EXOTE U.S. FOIA(0)(6) reported then noted notified the U.S. FOIA(0)(1) the NJ EXOTER 204(0)(1) but typic would trigger a NJ EXOTER U.S. FOIA(0)(1) but typic would trigger a NJ EXOTER U.S. FOIA(0)(1) but typic would trigger a NJ EXOTER NJ EXOTER 204(0)(1) but typic would trigger a NJ EXOTER U.S. FOIA(0)(1) but typic would trigger a NJ EXOTER NJ EXOTER 204(0)(1) but typic would trigger a NJ EXOTER 204(0)(1) but typic would trigger a NJ EXOTER 204(0)(1) but typic would trigger a NJ EXOTER 204(0)(1) but typic NJ EXOTER 204(0)(1) but typic N	done. Further review of the revealed that there was no nee that the resident was 205.4(b)(1) and a monthly VECOURTER ad within the EHR in VECOURTER is revealed that on VECOURTER is revealed the VECOURTER is revealed that the is the VECOURTER and the VECOURTER is revealed that the is the VECOURTER and the VECOURTER is revealed that request a VECOURTER is not not vectore is month of VECOURTER is not vectore is month of VECOURTER is not vectore is unable to explain why there NJ EX Order 26.4(b)(1) sheet. mented evidence that staff	F 69			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/31/2025 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	TIPLE CONSTRUCTION	CON	E SURVEY IPLETED C
		315524	B. WING			0 16/2024
	PROVIDER OR SUPPLIER BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER	STREET ADDRESS, CITY, STATE, ZIP CO 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	A review of the facil Intervention" policy, "Residents are weig intervals establishe team," and, "Weigh weight record chart record." Further re "Resident weights a or unintended weigh weight change of 5' weight assessment confirmation If the immediately notify t NJAC 8:39-17.4(a)' Respiratory/Trache CFR(s): 483.25(i) § 483.25(i) Respirat tracheostomy care The facility must en needs respiratory c care and tracheal s care, consistent wit practice, the compr care plan, the resid and 483.65 of this s This REQUIREMEN by: Based on observat review, and review documentation, it w failed to store Metacore	ity's "Weight Assessment and revised 03/2022, included, ghed upon admission and at d by the interdisciplinary ts are recorded in each unit's and in the individual's medical view of the policy included, are monitored for undesirable ht loss or gain," and, "Any % or more since the last is retaken the next day for e weight is verified, nursing will he dietician in writing." 1,3; 27.2 (a)(e) ostomy Care and Suctioning tory care, including and tracheal suctioning. sure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of ehensive person-centered ents' goals and preferences, subpart. NT is not met as evidenced ions, interviews, record	F 69		with we symptoms of currence. 4(b)(1) was anitized by ew weccer and	11/21/24

Event ID: UBXH11

Facility ID: NJ03015

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 315524 B. WING 10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 5000000000000000000000000000000000000			AND HUMAN SERVICES					FORM /	03/31/2025 APPROVED 0938-0391
315524 B. WING 10/16/2024 NAME OF PROVIDER OR SUPPLIER LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE JIA GROWING CONSUMPTION AND HEALTHCARE CENTER (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG CONVELTER D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG CONVELTER D PREFIX (EACH CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) OCONVELTER F 695 Continued From page 102 This deficient practice was evidenced by the following: F 695 On 10/8/24 at 1:11 PM, during the initial tour of the facility, the surveyor entered Resident #123's conducted an audi of current resident state that here resident's personal belongings. The Will EX ORDER/2010/U), The WILSCORD CAUGUY was stored on two of the four sides of the WILEX ORDER/2010/U). The WILSCORD CAUGUY was stored of a page and WILEX ORDER/2010/U), Was stored in a bag and WILEX ORDER/2010/U). The WILSCORD CAUGUY was stored on two of the four sides of the WILEX ORDER/2010/U). The WILSCORD CAUGUY was stored of the WILEX ORDER/2010/U). The WILSCORD CAUGU	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ° ′		N			
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY) (204) (204) CORRECTIVE APPROPRIATE DEFICIENCY) (204) (204) CORRECTIVE APPROPRI			315524	B. WING					
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER 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 PROVIDENS PLAN OF CORRECTION (EACH CORRECTY EATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DD DATE F 695 Continued From page 102 This deficient practice was evidenced by the following: F 695 bag that was labeled dated and appropriately stored away from the AC unit. Resident #123 AC unit was also cleaned and made free of dust particles. C. Current residents with order for nebulizer treatments have the potential to be affected by the cited occurrence. On 10/10/10/14 the Respiratory therapist conducted an audit of current resident belongings. The Twas noted in the NJ Ex Order 26.4(b)(1). A vast area of an unknown brown substance was noted on two of the four sides of the Size Construction of dust on the vent covers. The resident stated that the Size Construction of dust on the vent covers. The resident stated that the Size Construction of dust on the vent covers. The resident stated that the Size With the resident was unable to identify the brown matter on the Matterson of dust on the vent covers. 3. DON re-educated licensed nursing staff on the need to validate that respiratory equipment to include nebulizer machine, mask and tubing was clean, dry, appropriately stored in a sanitary manner to prevent the risk of infection. Staff education included those identified in the 2567	NAME OF F	PROVIDER OR SUPPLIER					ODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE F 695 Continued From page 102 This deficient practice was evidenced by the following: F 695 bag that was labeled dated and appropriately stored away from the AC unit. Resident #123 AC unit was also cleaned and made free of dust particles. C. Ourrent residents with order for nebulizer treatments have the potential to be affected by the cited occurrence. On 10/10/14 the Respiratory therapist conducted an audit of current resident identified with nebulizer treatment orders. Rounds were made to validate the equipment to include but not limited to the nebulizer machine, mask and tubing was clean, dry, appropriately stored in a sanitary manner. 3. DON re-educated licensed nursing staff on the need to validate that respiratory equipment to include not poing staff on the need to validate that respiratory equipment to include but not inmited to prevent the risk of infection. Staff education included those identified in the 2567	LAUREL	BROOK REHABILITA	ATION AND HEALTHCARE CENTE	ER					
This deficient practice was evidenced by the following: On 10/8/24 at 1:11 PM, during the initial tour of the facility, the surveyor entered Resident #123's room with permission and observed a Control of Second Second	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CO	ORRECTIVE ACTION	SHOULD	BE	COMPLETION
 A review of Resident #123's Admission Record, an admission summary, revealed that the resident had diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1) A review of Resident #123's Significant Change in Status Minimum Data Set, an assessment tool, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of source of 15, which indicated that the resident was NJ Ex Order 26.4(b)(1). A review of Resident #123's Order Summary 	F 695	This deficient practifollowing: On 10/8/24 at 1:11 the facility, the surv room with permission in the facility, the surv room with permission) that crowded table with belongings. The survey of the survey and NJ Ex Order 26 NJ Ex Order 26.4(b) unknown brown sult the four sides of the NJ Ex Order 26.4(b) unknown brown sult the four sides of the NJ Ex Order 26.4(b) unknown brown sult the four sides of the NJ Ex Order 26.4(b) A review of Resider an admission summaries A review of Resider and NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)	PM, during the initial tour of eyor entered Resident #123's on and observed a Verocerrector was not stored in a bag 6.4(b)(1)) was noted in the (1) . A vast area of an ostance was noted on two of e NJ EX Order 26.4(b)(1). The stored directly above a wall unit which had a thick coating covers. I that the Verocerrector that the Verocerrector hatter on the Verocerrector hatter on the Verocerrector hatter 26.4(b)(1) ht #123's Admission Record, mary, revealed that the oses which included but were x Order 26.4(b)(1)). ht #123's Significant Change in ata Set, an assessment tool, that the resident had a Brief I Status (BIMS) score of Verocert licated that the resident was 1).	F 6	bag that was appropriatel unit. Reside cleaned and 2. Current nebulizer tre be affected 10/10/14 the conducted a identified wi Rounds wer equipment t nebulizer ma clean, dry, a sanitary ma 3. DON re staff on the respiratory of machine, m appropriatel to prevent th education in 2567 4. The Res an audit of 3 nebulizer tre made to val but not limite mask and tu appropriatel Variances w will be cond monthly x 2 audits will bo Nursing to th and recomm	s labeled dated a ly stored away fr ent #123 AC unit d made free of du residents with o eatments have th by the cited occur e Respiratory the an audit of curren ith nebulizer trea re made to validat to include but not achine, mask an appropriately stor nner. -educated licens need to validate equipment to inc ask and tubing v ly stored in a sar he risk of infection active the equipment oncluded those ide spiratory therapis 3 residents identi- eatment orders. I idate the equipment of to the nebuliz- ubing was clean, ly stored in a sar vill be addressed lucted weekly x 4 months. The fin- e submitted by th he QAPI Commi-	rom the was also use parti- brider for he poter for he poter currence erapist in treside attent of attent of the timited in the timited in the timited in the timited in the timited is that clude ne was clear nitary mon. Staff entified with Rounds inter to in the time to inter the time to the t	icles. ntial to . On ent orders. I to the g was sing bulizer an, dry, anner ff in the ucted h s will be nclude hine, anner. e audits s, then f the ctor of review	

Facility ID: NJ03015

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		315524	B. WING				C 16/2024
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	Report revealed an "Change NJ EX Order 264(b)(1) [Specify Day and SI soiling and damage *Please date VECOURT A review of Resider Administration Reco with a start date of (NJ Ex Order 26.4((hours for NJ Ex Order 2 signed out as admin PM, prior to the sur On 10/9/24 at 12:35 Resident #123 lying that VECOURT air conditioning unit VECOURT was dated VECOURT air conditioning unit VECOURT was dated VECOURT plastic bag. A vast a substance was note the NJ Ex Order 26.4(b) During an interview at 12:40 PM, Licens stated that she noting was a little dirty from and that it needed t administered the re surveyor accompany room and pointed on had not yet been wid described. LPN #1 supposed to be stor	order dated Nervous to: 5.4(b)(1) and delivery device with for storage weekly on hift]. Change as needed for e. Every night shift every Wed 5.1 th #123's Medication ord (MAR) revealed an entry 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1	F6	95			

Facility ID: NJ03015

If continuation sheet Page 104 of 171

		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		315524	B. WING				C 16/2024
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	IR		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	Were shad a sin a bag when she arrived th that both the Were shift. The surveyor matter on the outsid and the thick coatin conditioner vents. T what could result if stored outside of the stored outside of the stored outside of the "Were still dirty. C Were stated, "That is c "Were still dirty, c NJ Ex Order 26.4(b) and labeled with the number, and dated Were still dirty, c NJ Ex Order 26.4(b) if it were still dirty, c "Were still dirty, c "Stated that if the bag and were expor- conditioner unit and someone's Were it was presponsible for NJ Ex bring it to their atter On 10/10/24 at 12:0 Resident #123 lying noticed that the NJ Ex	and had NJ Ex Order 26.4(b)(1) in it hat morning. LPN #1 stated and NF 0007 was changed last showed LPN #1 the brown de of the NJ Ex Order 26.4(b)(1) og of dust that covered the air the surveyor asked LPN #1 the NJ Ex Order 26.4(b)(1) were e bag with NJ Ex Order 26.4(b)(1) in the air conditioning unit and LPN disgusting. If the resident re was a chance of with the surveyor on 10/10/24 S. FOIA (b) (6) ated that she expected for)(1) to be stored in a bag e resident's name, room on both the bag and the bod for one week. The USFON e chamber to ensure that that ivered. The STON stated that if (1) were dirty then wipe it, and thange the NFON stated that if (1) were left out of the sed to dust and dirt on the air dyou put the NFON stated that if you put the NFON stated that if you put the NFON stated that if you put the NFON stated that if dyou put the NFON stated that if you put the NFON stated that you put the NFON stated that nursing was Order 26.4(b)(1), but she would ntion if she noticed it. D9 PM, the surveyor observed in bed awake. The surveyor x Order 26.4(b)(1) no longer had on it. The resident stated that	F 6	95			

Facility ID: NJ03015

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l • • •	PLE CONSTRUCTION		(X3) DATE	E SURVEY PLETED
AND FLAN C	CORRECTION	IDENTIFICATION NOWDER.	A. BUILDIN	G		(
		315524	B. WING			10/*	16/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3718 CHURCH ROAD	DDE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION			(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	\PPROPR	RIATE	DATE
F 695	Continued From pa	ge 105	F 69	5			
	During an interview	with the surveyor on 10/10/24					
	at 12:48 PM, the Lie	censed Practical Nurse/Unit					
) #4 stated that Resident •4(b)(1) should have been					
		The LPN/UM #4 stated that ed on cleaning the air					
	conditioner unit yes	terday, but he would get them					
	to come back again	n today if it was still not clean.					
	During an interview at 11:22 AM, the <mark>U.S</mark>						
	the ^{NJ Ex order 26.4(b)(1)} should	stated that d be wiped down and stored in					
	a plastic bag and la	beled and dated. The ^{US: FOIA (0)(6)} Was dated and changed					
	weekly and as need	ded. When asked what could					
	NJ Ex Order 26.4(b)(1) in the	vere left out of the bag with					
	conditioner unit, the	e ^{US.FOIA(0)(0)} stated that esult. The ^{US.FOIA(0)(0)} stated that					
	there was a risk for	infection if the NEXOTOGRADATION					
	were not w	viped down and kept clean.					
		with the surveyor on 10/15/24					
	at 10:58 AM, the U. stated that there wa	as a plastic bag where the					
	NJ Ex Order 26.4	(^{(b)(1)} of the <mark>NJ Ex Order 26.4(b)(1)</mark> ^{FOA (2)} stated that it was a					
	potential infection c	ontrol issue if it were not					
		the outside of the ^{NEXORDE 26.4(9)()} d to be cleaned. The ^{U.S. FOIA (2)}					
	stated there was a	chance of cross contamination ner machine vents should					
	have been cleaned.						
	A review of the facil	ity policy, "Administering					
	Medications through	h a Small Volume (handheld) n Date October 2010)					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION 315524 B. WING 10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 51 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/31/2025 APPROVED 0938-0391
Intervention of the section of the sectin of the section of the section of the section of the sec				· · /		Сом	PLETED
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) COMPLETIOL DATE F 695 Continued From page 106 revealed the following: "The purpose of this procedure is to safely and aseptically (free from contamination caused by harmful bacteria, viruses or other organisms) administer aerosolized particles of medications into the resident's airway. When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup. F 695			315524	B. WING			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 695 Continued From page 106 revealed the following: "The purpose of this procedure is to safely and aseptically (free from contamination caused by harmful bacteria, viruses or other organisms) administer aerosolized particles of medications into the resident's airway. When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup. F 695			TION AND HEALTHCARE CENTE	R	3718 CHURCH ROAD		
revealed the following: "The purpose of this procedure is to safely and aseptically (free from contamination caused by harmful bacteria, viruses or other organisms) administer aerosolized particles of medications into the resident's airway. When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
according to facility protocol, or: a. wash pieces with warm soapy water; b. rinse with hot water; c. place all pieces a bowl and cover with isopropyl (rubbing) alcohol. Soak for five minutes; d. rinse all pieces with sterile water (Not tap, bottled, or distilled); and e. allow to air dry on a paper towel When equipment is completely dry, store in a plastic bag with the resident's name and date on it. When equipment and tubing every seven days, or according to facility protocol. Disinfect outside of the compressor between residents, according to manufacturer's instructions." F 730 NJAC 8:39-19.4(a) Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) F 730 §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of \$483.95(g).	F 730	revealed the followin "The purpose of this aseptically (free from harmful bacteria, vin administer aerosoliz into the resident's a When treatment is and disconnect T-pi medication cup. Rinse and disinfer according to facility with warm soapy wa place all pieces a bo (rubbing) alcohol. S all pieces with steril distilled); and e. allow towel When equipment plastic bag with the it. Change equipment days, or according to Disinfect outside of residents, according instructions." NJAC 8:39-19.4(a) Nurse Aide Peform CFR(s): 483.35(d)(7) §483.35(d)(7) Regu The facility must co of every nurse aide months, and must p education based on reviews. In-service	ng: s procedure is to safely and m contamination caused by ruses or other organisms) zed particles of medications irway. s complete, turn off nebulizer iece, mouthpiece and ct the nebulizer equipment protocol, or: a. wash pieces ater; b. rinse with hot water; c. owl and cover with isopropyl oak for five minutes; d. rinse e water (Not tap, bottled, or ow to air dry on a paper is completely dry, store in a resident's name and date on nt and tubing every seven to facility protocol. of the compressor between g to manufacturer's Review-12 hr/yr In-Service 7) llar in-service education. mplete a performance review at least once every 12 provide regular in-service the outcome of these training must comply with the				11/21/24

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		AND HUMAN SERVICES			FORM	APPROVE
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COM	E <mark>SURVEY</mark> PLETED
		315524	B. WING _			C 16/2024
NAME OF F	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP		
				3718 CHURCH ROAD	OMB NO. 0 (X3) DATE: COMPI C 10/10 TE, ZIP CODE 054 N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JENCY) ents were identified. ions and in-service the outcome of ted for Nursing 8 on 11/6/24 and the both the supervisor . The files were audited erformance review of months. The Director validated current off are scheduled based on their performance reviews ed as indicated results. D (6) and Were re-educated on the policy for completion and Staff education fied in the 2567 or/designee will Nursing Assistant loyee anniversary performance reviews d and include based on the Zample and include based on the A weeks, then The findings of the ed by the QAPI Committee for endation monthly for 3	
LAUREL	BROOK REHABILIT	TION AND HEALTHCARE CENT		MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 730	Continued From pa	uge 107	F 73	0		
1 100		NT is not met as evidenced	175			
	facility documents, facility failed to com all Certified Nurse A twelve months and education based or performance review The deficient practic CNAs (CNA # 12 at completion of annu and was evidenced 1.) On 10/11/24 at reviewed the perso Nursing Assistants Staff Performance A Supervisor or Depa provided. The captic indicated, "This per reviewed and acknow Supervisor and Dep shall be placed in th Resource File. During an interview at 12:00 PM, the U make the employee Performance Appra- signed to confirm th the employee and the	ce was identified for 2 of 6 nd #8) reviewed for the al performance evaluations I by the following: 11:09 AM, the surveyor nnel files of five Certified and noted that the Annual Appraisal of CNA #12 dated signed by the employee, artment Head in the spaced on above the signature block formance appraisal has been owledged by the Employee, partment Head, and a copy ne employee's Human		 No specific residents of Performance evaluations a education based on the ou- reviews were completed for Assistant #12, and #8 on 1 were signed by both the bo- employee and their supervice. All CNA employee files for completion of a perform at least every twelve month of Nursing/Designee valida Nursing Assistant staff are performance review based anniversary date for perfor and education provided as based on evaluation result 3. The U.S. FOIA (b) (6) the U.S. FOIA (b) (6) the U.S. FOIA (b) (6) the U.S. FOIA (b) (6) the Administrator on the performance review comp in-service education. Staff included those identified in 4. The Administrator/des conduct 3 reviews of Nursi- files around the employee date to validate that perfor have been completed and in-service education based outcome of review. Varian- addressed. These audits v conducted weekly x 4 wee monthly x 2 months. The f audits will be submitted by Administrator to the QAPI review and recommendation. 	and in-service the service of or Nursing 11/6/24 and oth the visor . is were audited nance review of hs. The Director ated current is scheduled d on their rmance reviews indicated is. and re re-educated is policy for letion and education o the 2567 ignee will ing Assistant anniversary mance reviews include d on the ces will be visks, then indings of the the Committee for on monthly for 3	
	-	with the surveyor on 10/15/24		review and recommendate months or ongoing until co sustained.		

Facility ID: NJ03015
		AND HUMAN SERVICES			FORM	03/31/2025 APPROVED		
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION		MB NO. 0938-0391 (X3) DATE SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:	` ´			PLETED		
					(0		
		315524	B. WING		10/	16/2024		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD				
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	MOUNT LAUREL, NJ 08054				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 730	at 10:57 AM, the U. employee and their sign the CNA's perf 2.) On 10/11/24 at 1 copy of CNA #8's E Improvement Notifie EPIN revealed the f On CNA #8's CNA #8's NJ Ex Order 26.4b' to a CNA's assignment rounded on only on a long time, and the shift. Further review indic in-serviced on roun U.S. FOIA (b) (6) on Services call bells. On 10/16/24 at 11:1 for CNA #8, which it she was not in-services completing tasks.	S. FOIA (b) (6) stated that both the supervisor were required to formance appraisal. 12:35 PM, the USE FOIA (0) (0) provided a mployee Performance cation (EPIN). A review of the following: B received a verbal notice for M Ex Order 26.4b1 resident. Residents on the had complained of being ce, their call bells were on for e sheets on the bed were during the 11 PM to 7 AM cated that the CNA was ds with a verbal notice by the me grievance. There was no ervice for M Exorer a file M Exor and not answering 17 AM, the U.S. FOIA (b) (6) provided a summary ndicated for NJ Ex Order 26.4b1 ficed on NJ Ex Order 26.4b1	F 73					
		ity's "Staffing, Sufficient and						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315524	B. WING			C 10/16/2024	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 730	Competent Nursing included, "2. All nur specific competence respective licensure requirements5. C training for nursing monitored by nursin Competency requinursing leadership of director to ensure the programming for static competency; gaps in education and education topics and on the resident pop tracking or other mode evaluate the effective includes critical thin in a complex environ interruptions" A review of the facill Evaluations" (Verside revealed the followi "The job performant reviewed and evalut The written perfor contain the director and suggestions, and (e.g., further training The director and/de evaluated employed evaluated employed evaluation form. If the the form, the director and suggestions, and (e.g., further training The facility may and	" policy, revised August 2022, sing staff must meet the y requirements of their e and certification ompetency requirements and staff are established and ng leadership. irements and training for tablished and monitored by with input from the medical nat: aff training results in nursing re identified and addressed; d skills are determined based ulation; echanisms are in place to veness of training; and training king skills and managing care nment with multiple ity's undated "Performance on: 1.3 (H5MAPL0615)) policy, ng: ce of each employee shall be ated at least annually. mance evaluations will 's and/or supervisor's remarks ny action that should be taken g, etc.), and goals. or supervisor and the e should sign and date the he employee refuses to sign or and/or supervisor should	F 7	730			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF		(X3) DATE SURVEY	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	C	
		315524	B. WING			6/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER I	MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 730	Continued From pa	ge 110	F 730			
	NJAC 8:39-43.17(b Posted Nurse Staffi CFR(s): 483.35(g)(*	ng Information	F 732	2		11/21/24
	must post the follow basis: (i) Facility name. (ii) The current date (iii) The total number by the following cate unlicensed nursing resident care per sh (A) Registered nurs (B) Licensed practic	requirements. The facility ving information on a daily e. er and the actual hours worked egories of licensed and staff directly responsible for hift: ses. cal nurses or licensed as defined under State law). aides.				
	specified in paragra daily basis at the be (ii) Data must be po (A) Clear and reada	post the nurse staffing data uph (g)(1) of this section on a eginning of each shift. osted as follows: able format. blace readily accessible to				
	staffing data. The f written request, ma	c access to posted nurse acility must, upon oral or ke nurse staffing data lic for review at a cost not to nity standard.				
	§483.35(g)(4) Facili requirements. The	ity data retention facility must maintain the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED C NAME OF PROVIDER OR SUPPLIER 315524 STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 STREET ADDRESS, CITY, STATE, ZIP CODE 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 OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) (MPLET CONSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET (CONSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET (CONSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONFLET (CONSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONFLET (CONSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONTACT (CONSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONFLET (CONSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) <td< th=""><th></th><th colspan="4">DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES</th><th></th><th>FORM</th><th>03/31/2025 APPROVED 0938-0391</th></td<>		DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	03/31/2025 APPROVED 0938-0391
10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE X18 CHURCH ROAD MOUNT LAUREL, NJ 08054 MOUNT LAUREL, NJ 08054 (X4) ID 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 DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) (S) F 732 Continued From page 111 posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: F 732 F 732<		· · ·		1			COM	PLETED
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) COMPLETI DATE F 732 Continued From page 111 posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: F 732			315524	B. WING				
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER 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) COMPLETI DATE F 732 Continued From page 111 posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: F 732	NAME OF PROVIDER OR SUP	PLIER			STREET ADDRESS, C	ITY, STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETI DATE F 732 Continued From page 111 posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: F 732 F 732	LAUREL BROOK REHA	BILITATION A	ND HEALTHCARE CENT	ER				
posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	PREFIX (EACH DEF	CIENCY MUST BE	PRECEDED BY FULL	PREFI	(EACH COR	RECTIVE ACTION SHOULD RENCED TO THE APPROP	D BE	COMPLETION
 and review of other perturbation, it was determined that the facility failed to ensure that the current resident census was accurately reflected and recorded on the Nursing Home Resident Care Staffing Report prior to posting the notice in prominent areas for residents and the general public to view. This deficient practice was identified on three of six survey dates was evidenced by the following: On 10/8/24 at 9:11 AM, the USEFOIA(D)(6) stated that the facility census was 207. A review of the facility daily staffing sheet indicated that the resident census was 203. On 10/09/24 at 10:57 AM, the surveyor reviewed the Nursing Home Resident Care Staffing Report dated 10/8/24-Day Shift, reflected that the current census was 203. A review of the facility daily staffing sheet indicated that the resident census was 208. On 10/11/24 at 1:08 PM, the surveyor reviewed the Nursing Home Resident Care Staffing Report and noted that the census was 206. A review of the daily staffing sheet indicated that the resident census was 208. On 10/11/24 at 1:08 PM, the surveyor reviewed the Nursing Home Resident Care Staffing Report and noted that the census was 206. A review of the daily staffing sheet indicated that the resident census was 203. On 10/11/24 at 1:08 PM, the surveyor reviewed the Nursing Home Resident Care Staffing Report and noted that the census was 206. A review of the daily staffing sheet indicated that the resident census was 203. On 10/11/24 at 1:08 PM, the surveyor reviewed the Aurising Home Resident Care Staffing Report posted. Variances will be addressed. These audits will be submitted by the Administrator to the QAPI Committee for review and recormed and monothly for 3 	posted daily r 18 months, o is greater. This REQUIF by: Based on ob and review of was determin that the currer reflected and Resident Car notice in prori general public This deficient six survey da On 10/8/24 a census was 2 staffing sheet was 208. A rec Care Staffing reflected that 203. On 10/09/24 the Nursing H dated 10/9/24 census was 2 staffing sheet was 208. On 10/11/24 a the Nursing H and noted that the daily staff	urse staffing as required b EMENT is no servations, info other pertineled that the factor testident cerecorded on the staffing Rep inent areas for to view. practice was es was evide 9:11 AM, the 07. A review of indicated that view of the Ni Report dated the Current R at 10:57 AM, the ome Resident which reflect 03. A review of indicated that which reflect 03. A review of indicated that which reflect 03. A review of indicated that the census of the census of the census of the census of the census of the	by State law, whichever of met as evidenced terviews, record review int documentation, it cility failed to ensure insus was accurately the Nursing Home bort prior to posting the or residents and the identified on three of inced by the following: U.S. FOIA (b) (6) I stated that the facility of the facility daily t the resident census ursing Home Resident 10/8/24-Day Shift, tesident Census was the surveyor reviewed t Care Staffing Report ed that the current of the facility daily t the resident census		 No specific The three iden Information Sh accurate cens Administrator Current re be affected. O 10/15/24 the A audits to valida was accurately the Nursing Ha Report posted noted. The Admin U.S. FOIA (b) current resider reflected and r Home Resider to posting the for residents a view. Staff edu identified in the 4. The Admin conduct 3 aud resident censu and recorded a Resident Care Variances will will be conduc monthly x 2 m audits will be s Administrator 	ntified Nurse Staffing neets were corrected us information by the sidents have the pot n 10/11/24, 10/14/24 Administrator conduct ate current resident of y reflected and recor- ome Resident Care 3 . No further variance instrator re-educated (6) on the need for instrator re-educated (6) on the need for need to be accu- recorded on the Nurse notice in prominent a notice in prominent a notice in prominent a notice in prominent a sud the general publi- ucation included those e 2567 nistrator/designee wi its to validate current is was accurately re- on the Nursing Hom e Staffing Report poss be addressed. Thes ted weekly x 4 week onths. The findings of submitted by the to the QAPI Commit	I with e tential to 4, & cted census rded on Staffing es were I the or urately sing ort prior areas c to se ill t flected e e audits rs, then of the tee for	

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		AND HUMAN SERVICES			FORM	APPROVED
		& MEDICAID SERVICES			MB NO. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
					(c
		315524	B. WING		10/*	16/2024
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R I	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
F 732	Continued From pa	ge 112	F 73	2		
	During an interview	with the surveyor on 10/11/24		sustained.		
	at 1:09 PM, the U.S	. FOIA (b) (6)) stated				
	that the current cen	sus was 203. The stated Nursing Home Resident Care				
		the current census based on				
		mulated from the computer				
		sed. When the surveyor ent resident census of 203 that				
		ed from the recorded resident				
		206 on the Nursing Home				
	Resident Care Staf	fing Report that was posted in				
	the main lobby, the	"The ^{user} stated, "I was not aware "The ^{user} stated that she				
	obtained the daily re	esident census number during				
	a group meeting an	d any pending admissions				
		re reflected on the form prior				
	to posting the follow					
	at 1:38 PM, the U.S	with the surveyor on 10/11/24 FOIA (b) (6) stated				
	that the current resi	ident census was 203. When				
		sing Home Resident Care				
	Staffing Report that	t was posted in the main lobby of 206, the ^{us folde} stated that				
	the he would follow	up with the us re and clarify why				
	she did not list the o					
	During an interview	with the surveyor on 10/15/24				
		stated that the Business				
		midnight census report and				
		o did not have an updated outer software, so the				
		made was not based on the				
		he stated that if the				
	reported resident ce	ensus were not accurate, it				
		accuracy. The use for the higher				
		the facility could have				
		luty, and if it were under, the				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315524	B. WING			C 16/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	RI	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) Completion Date
F 732 F 755 SS=D	inverse pattern of to A review of the facil and Competent Nur 2022) revealed the "Minimum staffing state, if applicable, determining staff ra considered a deterr competent staff. Direct care daily so of nursing personned direct care to reside for every shift. Inquiries or conce staffing should be d nursing services (D NJAC 8:39-41.2(c) Pharmacy Srvcs/Pr CFR(s): 483.45(a)(f §483.45 Pharmacy The facility must pro- drugs and biological them under an agre §483.70(f). The fac personnel to admini- permits, but only un a licensed nurse. §483.45(a) Procedu pharmaceutical ser- that assure the accor-	 bo few staff may be on duty. ity policy, "Staffing, Sufficient rsing" (Revision Date August following: grequirements imposed by the are adhered to when tios but are not necessarily nination of sufficient and taffing numbers (the number el responsible for providing ents) are posted in the facility erns relative to our facility's irected to the director of NS) or his/her designee." (d) ocedures/Pharmacist/Records b)(1)-(3) Services by the and emergency is to its residents, or obtain 	F 73			11/21/24

Facility ID: NJ03015

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315524	B. WING				C 16/2024
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CO	ODE	
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		URCH ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	§483.45(b) Service must employ or obt pharmacist who- §483.45(b)(1) Provi aspects of the prov the facility. §483.45(b)(2) Estal receipt and disposit sufficient detail to e reconciliation; and §483.45(b)(3) Dete order and that an a is maintained and p This REQUIREMEN by: Complaint #: NJ17 Based on observati record review, it wa failed to a.) ensure Narcotic Shift Coun accordance with fac narcotics were prop secured locks per f and administer a m This deficient pract medication carts re and 1 of 5 residents	Consultation. The facility ain the services of a licensed ides consultation on all ision of pharmacy services in blishes a system of records of tion of all controlled drugs in nable an accurate rmines that drug records are in ccount of all controlled drugs periodically reconciled. NT is not met as evidenced	F 7	1. F the fa A full with r Signa 2 lice The r repla pharr 2. (be af audit cons Shift acco medi	Resident #355 NJ Ex Order acility. I house count was atures of the count was ensed nurses unidentified Metoderases unidentified Metoderases unidentified Metoderases unidentified Metoderases indentified by the count was fected by the cited occur t was completed 10/10/2 istent accountability of t Count logs were compl rdance with facility polic ication carts narcotics w	vas completed e recorded by k box lid was alidated by the 10/24. the potential to urrence. An 24 to validate the Narcotic leted in cy, and vere properly	
	presence of Register reviewed the Nexonerse	45 AM, the surveyor, in the ered Nurse #1 (RN #1), Unit's medication B Cart c count logs which indicated		In ad on Xa resid	red under two secured Idition, an audit of reside arelto was completed to lents were administered linical provider orders o	ents that are o validate that I medication	

Facility ID: NJ03015

		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		315524	B. WING				_ 16/2024
NAME OF	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP COL		10/2024
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER	I	718 CHURCH ROAD NOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 755	Continued From pa	ge 115	F	755			
	the following missir Nurse's signature g - 3 PM shift Nurse's signature o - 7 AM shift Nurse's signature o - 3 PM shift The "Is count corre- blank for all shifts fit At that time, the sur- stated that the inco- were supposed to p together at each shi count log and sign was performed and stated that there wa documentation or n On 10/10/24 at 1:50 the U.S. FOIA (b) (incoming and outgo perform the narcoti cart at each shift ch accountability reaso that there should be "probably not accept" is count correct?" fit 2.) On 10/10/24 10 presence of RN #1 medication B Cart at the narcotic lock bo medication cart dra lock box by the edg revealing narcotics The lock box was th	and documentation: Joing off duty for 9/26/24 7 AM soming on duty 10/9/24 11 PM soming on duty 10/10/24 7 AM coming on duty 10/10/24 7 AM ct: Yes / No" column was rom 9/26/24 through 10/10/24 rveyor interviewed RN #1 who ming and outgoing nurses berform the narcotic count lift change and complete the it together to indicate the count l accurate. The RN further as not to be any missing bursing signatures. D PM, the surveyor interviewed 3) who stated that the bing nurses were expected to c count for each medication		755	the Director of Nursing. No f findings. 3. The DON/ designee re-econ licensed nurses on the facility accountability of the Narcotic logs and need for consistent of the need to validate medication narcotics are properly secure secured locks with immediate Administrator notification with and the need to administer m such as Xarelto per physician Education further indicated if medication is not available the should be contacted followed notification to the clinical prov further guidance. Notifications documented. Barriers or findin be immediately reported to the or the Director of Nursing. Statincluded those identified in the 4. The DON/designee will cor rounds to validate consistent accountability of the Narcotic logs were completed in accord facility policy, and medication narcotics were properly secur two secured locks. In addition, an audit of 3 resid Xarelto will be completed to v residents were administered r per clinical provider orders. Va be addressed. These audits v conducted weekly x 4 weeks, monthly x 2 months. The findia audits will be submitted by the Nursing to the QAPI Committe and recommendation monthly	ducated policy on Shift Count completion, on carts d under two DON and or variances edications orders. the e pharmacy by ider for s should be ngs should e Supervisor aff education e 2567 omplete 3 Shift Count dance with carts red under lents on alidate that medication ariances will vill be then ings of the e Director of ee for review	

Facility ID: NJ03015

	MENT OF HEALTH		FORM	03/31/2025 APPROVED 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315524	B. WING _			C 16/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 755	of the box being op lid and engaged the the lid with the sam box open without us stated that the lock position and should key. She then confil be opened without a On 10/10/24 at 11:4 the U.S. FOIA (b) (0 the Neroscial medicat #1 and handling the time, the surveyor in stated they "will hav take a look at it." On 10/10/24 at 1:50 the Medicat that no one should without a key. On 10/16/24 at 9:15 narcotic lock box no contents of the box email that a pharma the medication cart addressed on 10/10 A review of the facil Dangerous Substar of October 2023 in "the controlled dang double locked at all The key to the med possession of the n	ened. The RN then closed the elocking latch and tugged on e result of having the narcotic sing a key. The RN then box was always in a locked open only with the use of a rmed that this box was able to a key and minimal effort. 2 AM, the surveyor observed (a) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c	F 75	55 sustained.		

		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	1 ° '			COMPLETED	
		315524	B. WING _			C 10/16/2024	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 755	incoming and outgo shift both nurses Pharmacy Controlle 3.) The surveyor re- electronic medical reco following: A review of the Adm summary) revealed admitted to the facili included, but were re admitted to the facili admitted to the facili admitted to the facili admitted for a state NJ Ex Order 26.4(b)(1) A review of the indiv dated for a state administer medic A review of the Actini dated for a state administer for state N Ex Order 26.4(b) A review of the corr Medication Adminis	bing nurse at the change of sign the count on the ed Drug Record." viewed Resident #355's records (EMR) records and the rds which revealed the hission Record (an admission that the resident was lity with diagnoses which not limited to; WEXCORE 26.4(b)(1) JEX Order Summary Report, ided a physican's order (PO) 4(b)(1) tablet; give one he evening for JEX Order 26.4(b)(1) tration Record (MAR)	F 75	55			
	shift both nurses Pharmacy Controlle 3.) The surveyor re- electronic medical reco following: A review of the Adm summary) revealed admitted to the facil included, but were r , and A review of the Soc dated I admitted to the facil included, but were r , and A review of the Soc dated I admitted to the facil included, but were r , and A review of the Soc dated I admitted to the facil included, but were r , and A review of the Soc dated I admitted to the facil of NJ Ex Order 26.4(b)(1) A review of the indiv dated I administer medic A review of the Actin dated I administer medic A review of the Actin dated I administer for sign A review of the corr Medication Adminis	sign the count on the ed Drug Record." viewed Resident #355's records (EMR) records and the rds which revealed the hission Record (an admission that the resident was lity with diagnoses which not limited to; NECOURT 26.4(b)(1) JEX Order 26.4(b)(1) JEX Order 26.4(b)(1) JEX Order 26.4(b)(1) ial Services Assessment, aled the resident was ad did not exhibit any behavior vidual baseline care plan, aled that the resident was on D(1) () therapy related to D(1) () with an intervention ration as ordered. ve Order Summary Report, aded a physican's order (PO) 4(b)(1) tablet; give one he evening for for 14 gns and symptoms (s/s) of					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315524	B. WING _			C 16/2024
	PROVIDER OR SUPPLIER	TION AND HEALTHCARE CENTE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	Code located on the "hold." A review of the corr not include docume "become and was held. A Physician History "become and at 1:22 PM, informed the doctor receive their medica On 10/10/24 at 10:2 interviewed License who stated that if a in the medication ca backup house stock Dispensing System was not available in then the nurse cont when the medicatio the doctor to get an medication. The sur NJ Ex Order 26.4(b)(1) M confirmed it was he documented hold, t unavailable. LPN #2 admission came in medication available house stock medica acknowledged that	had a number "5" nurse. A review of Chart e MAR, indicated a "5" was esponding Progress Notes did entation on """""", for why the and """"""", for why the and """""""", for why the and """"""""""""""""""""""""""""""""""""	F 75			
		30 AM, the U.S. FOIA (b) (6) provided the surveyor with an tions located in the backup				

Facility ID: NJ03015

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		AND HUMAN SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLI	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG _		COMPLETED	
		315524	B. WING				C 16/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
F 755	Continued From pa	ae 119	F 75	55			
		led that WEX ONCE 2544 was not a					
	medication available	e in the backup system.					
)7 AM, the surveyor					
		N Unit Manager (LPN/UM#1), medication was not available					
		ock or in the AMDS, then the					
		e doctor or the pharmacy to cation would be available.					
		that they were unsure if					
	was a medi	cation available in the AMDS,					
		ne AMDS, the nurse should rmacy and see when it would					
		e or notified the doctor.					
	On 10/10/24 at 11:3	32 AM, the surveyor					
	interviewed the U.S	. FOIA (b) (6)), who					
		iewed the AMDS inventory list and they confirmed that					
		the list. The stated that if a					
		available, the nurse should					
		rmacy to find out when it and notified the doctor. The					
	CP further stated th	at N Ex order 26.4 should be given as					
	ordered because it given, it increased r	Was a ^{NJ Ex Order 26.4(b)(1)} and if not					
		2 PM, the surveyor interviewed					
	the U.S. FOIA (b) (6 would have expected	b) who stated they ed the nurses to notify the					
	pharmacy if a medi	cation was not in the AMDS or					
		and notify the physician. The that a number "5" code on the					
	MAR meant not adr	ministered and the nurse					
	should have notified	the physician and wrote a					
		s Notes. The ^{US FOACE} stated that Order 26.4(0)(1) so "you want to					
	make sure the resid	dent was monitored for					
	potential NEXOTA issue	'S."					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	(X3) DATE) DATE SURVEY COMPLETED	
			A. BUILDIN	NG		C
		315524	B. WING		10/*	16/2024
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD		
LAUREL	LAUREL BROOK REHABILITATION AND HEALTHCARE CEN			MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	Continued From page 120 F 755					
	A review of the facil Medication", dated the event that medi- noted to be unavailable dispensed, nursi "a. Contact the phar medication b. Attempt to obtain Automated medicate emergency kit c. Notify the physici medication, explain date of expected availernative medicati pharmacy. i. obtain prior order or; ii obtain prior order or; ii obtain prior order or; ii obtain NJAC 8:39-27.1(a) NJAC 8:39-29.7(c) Free from Unnec Pe CFR(s): 483.45(c)(3) §483.45(c)(3) A psy affects brain activitie processes and behavious construction processes and behavious construction the event that medicate the event the event the event the event medication obtain attempt to obtain medication obtain the event the event the event the event state of expected available medicate the event the event the event the event the event the event state of event the	ity's policy titled "Unavailable June 2021, revealed that in cation ordered for a resident is able near or at the time it is to ing staff shall: rmacy regarding unavailable the medication from the ion dispensing system or an of the unavailable the circumstances, report the vailability, and provide the on(s) recommended by anew order and discontinue ain a hold order for the tion." sychotropic Meds/PRN Use 3)(e)(1)-(5) tropic Drugs. vchotropic drug is any drug that es associated with mental avior. These drugs include, o, drugs in the following	F 75			11/21/24
		hensive assessment of a must ensure that				

Facility ID: NJ03015

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CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO.0330.4391 STATEMENT OF DEFINITION NUMBER: (PROVIDER UNPERICATION NUMBER: (PROVIDER UNPERICATION NUMBER: AMB OF PROVIDER OR SUPPLIER 315524 B. WNG LAUREL BROCK REHABILITATION AND HEALTHCARE CENTER STREET ADRESS, CITY, STATE, 2P CODE JAME OF PROVIDER OR SUPPLIER 315524 LAUREL BROCK REHABILITATION AND HEALTHCARE CENTER STREET ADRESS, CITY, STATE, 2P CODE JAME OF PROVIDER OR SUPPLIER 315524 LAUREL BROCK REHABILITATION AND HEALTHCARE CENTER PROVIDER YEAR NO F CORRECTION (PROVIDE) PROVIDER YEAR OF CORRECTION (PROVIDE) PROVIDE P			AND HUMAN SERVICES			FORM	03/31/2025 APPROVED	
AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING COMPLETED 31524 B. WING C C NAME OF PROVIDER OR SUPPLICE STREET ADDRESS, CITY, STATE, 2PF CODE STREET ADDRESS, CITY, STATE, 2PF CODE LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, 2PF CODE STREET ADDRESS, CITY, STATE, 2PF CODE MID OF PROVIDER OR SUPPLICE STREET ADDRESS, CITY, STATE, 2PF CODE STREET ADDRESS, CITY, STATE, 2PF CODE MOUNT LAUREL, NJ 08054 PROVIDER OR SWOLD BE COMPLETED MOUNT CALVEREL, NJ 08054 PROVIDER OR SWOLD BE COMPLETED PARE OF CONTINUES THE PRECEDED BY FULL PROVIDER OR SWOLD BE COMPLETED S483.45(e)(1) Residents who have not used PROVIDER OR SWOLD BE COMPLETED S483.45(e)(2) Residents who have not used Provide rescue to THE APROPRIATE DEFICIENCY S483.45(e)(2) Residents who use psychotropic F758 F758 S483.45(e)(2) Residents do not receive S483.45(e)(2) Residents do not receive Psychotropic drugs pursuant to a PRN order F758 S483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in S483.45(e)(4) PRN orders for anti-psychotic drugs are limited to 14 days. Except as provided in S483.45(e)(4) PRN orders for anti-psychotic drugs are limited								
C Index of PROVIDER OR SUPPLIER INME OF PROVIDER SPLAN OF DEFICIENCIES PROVIDERS IFLAN OF CORRECTION BY EDUCATION WAS TREMENT OF DEFICIENCIES PROVIDERS IFLAN OF CORRECTION BY EDUCATION OR LSCI DENTIFYNG INFORMATION PREFIX Continued From page 121 F 758 F 758 Continued From page 121 F 758 S483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; S483.45(e)(2) Residents do not receive psychotropic drugs previous to a PRN order unless that medication is necessary to treat a diagnosed specific condition as provided in a propriate resolution the is documented in the clinical record; and S483.45(e)(1) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in a propriate resolution their rationale in the resident's medical record and indicate the duration for the PRN order. S483.45(e)(1) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescrining practinoner								
MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE JAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE PAYIND TAG SUMMARY STATEMENT OF DETICIENCES (EAC) DEPRICIENCY MUST DE PRECEDED BY FULL (EAC) CORRECTIVE AUTORY OR IS CENEEDED BY FULL (EAC) CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY) OP (EAC) CORRECTIVE ACTION ACTION (EAC) CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY) OP (EAC) CORRECTIVE ACTION ACTION (EAC) CORRECTIVE ACTION ACTION (EAC) CORRECTIVE ACTION ACTION (EAC) CORRECTIVE ACTION (EAC) CORRECTIVE ACTION ACTION (EAC) CORRECTIVE ACTION (EAC) CORRECTIVE ACTION ACTION (EAC) CORRECTIVE						С		
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER 378 CHURCH ROAD MOUNT LAUREL, NJ 08054 (A) ID PRETRY TAC SUMMARY STATEMENT OF DEFICIENCIES (EACH ORRECTIVE ACTION BROUDD BE FINANCE In DROWING STATEMENT OF DEFICIENCIES (EACH ORRECTIVE ACTION BROUDD BE EACH ORRECTIVE ACTION BROUDD BE EACH ORRECTIVE ACTION BROUDD BE (EACH ORRECTIVE ACTION BROUDD BE (EACH ORRECTIVE ACTION BROUDD BE EACH ORRECTIVE ACTION BROUDD BE (EACH ORRECTIVE ACTION BROUDD BE EACH ORRECTIVE ACTION BROUDD BE (EACH ORRECTIVE ACTION BROUDD BE EACH ORRECTIVE ACTION BROUDD BE (EACH ORRECTIVE ACTION BROUDD BE S483.45(e)(2) Residents who have not used prophysication is necessary to treat a diagnosed specific condition that is documented in the clinical record; S483.45(e)(2) Residents do not receive prophysication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and S483.45(e)(5), fit the attending physician or prescribing practitioner believes that it is appropriate for the PRN order. S483.45(e)(5), RN orders for psychotroic drugs are limited to 14 days. Except as provided in y483.45(e)(5), RN orders for anti-psychotic drugs are limited to 14 days and cannot be reneved unless that attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility factore as Reviewed by 1. Resident #17/MER ORDER 24(00X) in the facint facility 40 was reviewed by <td></td> <td></td> <td>315524</td> <td></td> <td></td> <td>10/1</td> <td>6/2024</td>			315524			10/1	6/2024	
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER MOUNT LAUREL, NJ 08054 (%1) D PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCE) BY FULL REGULATIONY OR LISC DEXTREMENT OF DEFICIENCIES (EACH DEPICIENCY MIST BE REFORED BY FULL REGULATIONY OR LISC DEXTREMENT OF DEFICIENCIES (EACH DEPICIENCY) PRETX PRETX TAG PROVIDERS AND OF CORRECTION (EACH DEPICIENCY) CORPT (EACH DEPICIENCY) F 758 Continued From page 121 F 758 S483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; F 758 \$483.45(e)(2) Residents who use psychotropic drugs; \$483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; \$483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and \$483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order. \$483.45(e)(5), PRN orders for anti-psychotic drugs are limited to 14 days. Lex perts are evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by; Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility facilate to a), address 1. Resident #17 SUES ONE 204001 in the facility Resident #10 was reviewed by <td>NAME OF F</td> <td colspan="3">NAME OF PROVIDER OR SUPPLIER</td> <td></td> <td></td> <td></td>	NAME OF F	NAME OF PROVIDER OR SUPPLIER						
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DEFICIENCY)	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	¢	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE	
 F 758 Continued From page 122 (GDR) of <u>Product action</u> medications (CR) medications), b.: I near as needed (PRN) <u>Product action</u> medications were prescribed with a 14-day duration and re-evaluated for continued use, and c.) adequately monitor target behaviors for the use of <u>Product action</u> medications for 5 of 6 residents (Resident #10, 40, 4109, #167, and #358) reviewed for unnecessary medications. This deficient practice was evidenced by the following: 1.) On 10/9/24 at 12:36 PM, the surveyor observed Resident #17 Mad iagnoses which included, but were not limited to <u>Product 28.4(b)(1)</u>. A review of the Admission Record (an admission summary). Resident #17 had diagnoses which included, but were not limited to <u>Product 28.4(b)(1)</u>. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated <u>Product 28.4(b)(1)</u>. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated <u>Product 28.4(b)(1)</u>. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated <u>Product 28.4(b)(1)</u>. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated <u>Product 28.4(b)(1)</u>. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the resident had <u>Prior Contract 28.4(b)(1)</u>. A review of the individualized comprehensive care plan (ICCP), initiated <u>Prior 28.4(b)(1)</u>. A review of the individualized comprehensive care plan (ICCP), initiated <u>Prior 28.4(b)(1)</u>. A review of the individualized comprehensive care plan (ICCP), initiated <u>Prior 28.4(b)(1)</u>. <li< td=""><td>F 758</td><td>(GDR) of WEX Order 2044 medication: (PRN) WEX order 2044(b)(1) with a 14-day durat continued use, and behaviors for the us for 5 of 6 residents #167, and #358) re- medications. This deficient pract following: 1.) On 10/9/24 at 12 observed Resident was in a NJ EX Order 26 A review of the Adn summary), Resider included, but were NJ EX Order 26.4(b A review of the adm (MDS), an assess management of call the resident had a I Status score of ME resident's cognition the MDS revealed the and received NJEX Order A review of the indir plan (ICCP), initiate resident used NJEX OF</td><td>(W) medications (W Exceeded medications were prescribed ion and re-evaluated for c.) adequately monitor target se of W Exceeded (Resident #17, #40, #109, viewed for unnecessary) ice was evidenced by the 2:36 PM, the surveyor #17 lying in bed. The resident 4(9(0) and had no complaints. hission Record (an admission ht #17 had diagnoses which not limited to, N Exceeded which not limited to, N Exceeded (I) (I) , and W Exceeded (I) (I) , and W Exceeded Brief Interview for Mental out of 15, which indicated the was W Exceeded Further review of the resident had [N Ex Order 26.4(b)(1) of [N Ex Order 26.4(b)(1) medications).</td><td>F 7</td><td>58</td><td>Neccess evaluation. Neccessed mon was initiated on Neccessed mon ordered. Resident #40 and Neccessed evaluation Neccessed mon started on Neccessed mon was ordered. Resident #109 and was ordered. Resident #358 me was reviewed by the provider an was discontinued on Neccessed was reviewed by the provider an was discontinued on Neccessed was completed to validate reside psychotropic medications had be monitoring in place, reviews for dose reduction of psychotropic medications were completed pe policy and documented and resi receiving as needed (PRN) psyc medications were prescribed wit 14-day duration and reevaluated continued use per regulatory gui Variances were addressed. 3. The DON/designee re-educate licensed nurses and Social Wort the facility psychotropic policy to but not limited to validate reside psychotropic medications had be monitoring in place, reviews for dose reduction of psychotropic medications were prescribed with a facility psychotropic policy to but not limited to validate reside psychotropic medications had be monitoring in place, reviews for dose reduction of psychotropic medications the facility psychotropic policy to but not limited to validate resided psychotropic medications had be monitoring in place, reviews for dose reduction of psychotropic medications were prescribed with a 14-day d and reevaluated for continued us regulatory guidelines. Staff educ</td><td>rovider was iewed by review of toring was er dication dication dication dication ehavior gradual r facility dent chotropic th a d for idelines. red kers on include nts on ehavior gradual d for idelines.</td><td></td></li<>	F 758	(GDR) of WEX Order 2044 medication: (PRN) WEX order 2044(b)(1) with a 14-day durat continued use, and behaviors for the us for 5 of 6 residents #167, and #358) re- medications. This deficient pract following: 1.) On 10/9/24 at 12 observed Resident was in a NJ EX Order 26 A review of the Adn summary), Resider included, but were NJ EX Order 26.4(b A review of the adm (MDS), an assess management of call the resident had a I Status score of ME resident's cognition the MDS revealed the and received NJEX Order A review of the indir plan (ICCP), initiate resident used NJEX OF	(W) medications (W Exceeded medications were prescribed ion and re-evaluated for c.) adequately monitor target se of W Exceeded (Resident #17, #40, #109, viewed for unnecessary) ice was evidenced by the 2:36 PM, the surveyor #17 lying in bed. The resident 4(9(0) and had no complaints. hission Record (an admission ht #17 had diagnoses which not limited to, N Exceeded which not limited to, N Exceeded (I) (I) , and W Exceeded (I) (I) , and W Exceeded Brief Interview for Mental out of 15, which indicated the was W Exceeded Further review of the resident had [N Ex Order 26.4(b)(1) of [N Ex Order 26.4(b)(1) medications).	F 7	58	Neccess evaluation. Neccessed mon was initiated on Neccessed mon ordered. Resident #40 and Neccessed evaluation Neccessed mon started on Neccessed mon was ordered. Resident #109 and was ordered. Resident #358 me was reviewed by the provider an was discontinued on Neccessed was reviewed by the provider an was discontinued on Neccessed was completed to validate reside psychotropic medications had be monitoring in place, reviews for dose reduction of psychotropic medications were completed pe policy and documented and resi receiving as needed (PRN) psyc medications were prescribed wit 14-day duration and reevaluated continued use per regulatory gui Variances were addressed. 3. The DON/designee re-educate licensed nurses and Social Wort the facility psychotropic policy to but not limited to validate reside psychotropic medications had be monitoring in place, reviews for dose reduction of psychotropic medications were prescribed with a facility psychotropic policy to but not limited to validate reside psychotropic medications had be monitoring in place, reviews for dose reduction of psychotropic medications the facility psychotropic policy to but not limited to validate resided psychotropic medications had be monitoring in place, reviews for dose reduction of psychotropic medications were prescribed with a 14-day d and reevaluated for continued us regulatory guidelines. Staff educ	rovider was iewed by review of toring was er dication dication dication dication ehavior gradual r facility dent chotropic th a d for idelines. red kers on include nts on ehavior gradual d for idelines.		

Facility ID: NJ03015

If continuation sheet Page 123 of 171

		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	Сом	E SURVEY PLETED	
		315524	B. WING			C 10/16/2024		
	PROVIDER OR SUPPLIER	ATION AND HEALTHCARE CENT	ER	37	TREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD OUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACT		BE	(X5) COMPLETION DATE	
F 758	physician to consid clinically appropriat A review of the NUEXO eval), dated NUEXO Further review of the har recommendations of NUEXO A review of the Nur written by NP #2 an "NUEXO A review of the Nur written by NP #2 an "NUEXO GDR that were mad A review of the note of addressed the NUEXO GDR that were mad A review of the NUEX Administration Rec following physician -NJ EX Order 26.4(b)(1) for with an order date of NUEXO	er dosage reduction when e." rer 2034(b)(1) Evaluation ("LEX OTHER 2 , revealed the resident d been refusing NJ EX OTHER 2 because it gave because it gave could be the day prior. could be object to the day prior. could be day prior. could be day prior. could be object to the day prior. could be day prior. could be object to the day prior. could be day prior. could be day prior. could be day for N Ex Other 284(b)(1) be object to the day for N Ex Other 284(b)(1) be object to the day for N Ex Other 284(b)(1) could be day for N Ex Other 284(b)(1) be other 284(b)(1) MAR included the orders: b)(1) uth once a day for N Ex Other 284(b)(1) of N Ex Other 284(b)(1) MAR included the orders: b)(1) uth once a day for N Ex Other 284(b)(1) of N Ex Other 284(b)(1) MAR included the orders: b)(1) uth once a day for N Ex Other 284(b)(1) of N Ex Other 284(b)(1) MAR included the orders: b)(1) uth once a day for N Ex Other 284(b)(1) of N Ex Other 284(b)(1) MAR included the orders: b)(1) uth once a day for N Ex Other 284(b)(1) of N Ex Other 284(b)(1) MAR included the orders: b)(1) th once a day for N Ex Other 284(b)(1) of N Ex Other 284(b)(1) MAR included the orders: b)(1) could be dottime for N Ex Other 284(b)(1) by mouth at be dtime for N Ex Other 284(b)(1) by mouth at be dtime for N Ex Other 284(b)(1) by mouth at be dtime for N Ex Other 284(b)(1) by mouth at be dtime for N Ex Other 284(b)(1) by mouth at be dtime for N Ex Other 284(b)(1) by mouth at be dtime for N Ex Other 284(b)(1) by mouth at be dtime for N Ex Other 284(b)(1) by mouth at be dtime for N Ex Other 284(b)(1) could be dtime for N Ex Other 284(b)(1) could be dtime for N Ex Other 284	F 7	58	The DON/designee will conduct an on 3 residents with orders for psychotropic medications to validat residents on psychotropic medication had behavior monitoring in place, re for gradual dose reduction of psych medications were completed and documented and resident receiving needed (PRN) psychotropic medicat were prescribed with a 14-day dura and reevaluated for continued use regulatory guidelines. Variances wil addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings o audits will be submitted by the Dire Nursing to the QAPI Committee for and recommendation monthly for 3 months or ongoing until compliance sustained.	e that ons eviews notropic as ations tion per I be f the ctor of review		

		AND HUMAN SERVICES				FORM	APPROVED
	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN C	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					COMPLETED	
		315524	B. WING			C 10/16/2024	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL BROOK REHABILITATION AND HEALTHCARE CENT			ER		718 CHURCH ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 758	During an interview at 11:50 AM, Certific	ge 124 with the surveyor on 10/15/24 ed Nursing Assistant (CNA) #2 7 NJ Ex Order 26.4b1	F 7	58			
	During an interview at 11:55 AM, Licens stated the US. FOIA (b) and if recommenda would follow-up with further stated that should be addressed	with the surveyor on 10/15/24 sed Practical Nurse (LPN) #4 came to the facility weekly tions were made, the nurse in the physician. The LPN recommendations recommendations ed immediately to "see if the orking and keep the resident					
	at 12:09 PM, the U.) stated wh N Ex order 254(0)(1) medic ordered to see if the a GDR. The USTRATOR U.S. FOIA (b)(6) made a physician would rev resident's EMR and recommendations a asked about Reside the resident was sti that if NP #2 saw th eval, the NP should recommendations. that it was important recommendations t time the resident is appropriate."	en a resident was on a ation, a ^{NETORER} eval was e resident was appropriate for explained that when the recommendation, the view the ^{NETORER} eval in the address the as soon as possible. When ent #17, the ^{USTOCAD} confirmed II ordered the ^{NETORER} confirmed II ordered the ^{NETORER} and re resident after the ^{NETORER} have addressed the The ^{USTOCAD} further stated					

		AND HUMAN SERVICES				FO	ED: 03/31/2025 RM APPROVED	
					E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ° '				COMPLETED	
				-			С	
		315524	B. WING				10/16/2024	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETION DATE	
					DEFICIENCY)			
F 750		405		_				
F 758		-	F 75	8				
		should be verified and ding to the provider. The						
		that the provider should						
		sident's medical record when						
	recommendations v	were reviewed.						
	2.) On 10/08/24 at §	9:31 AM, the surveyor						
	observed Resident	#167 in his/her room.						
	A review of the Adm	nission Record (admission						
		the resident had diagnoses						
	which included, but	were not limited to,						
	NJ Ex Order 28.4(b)	⁽¹⁾ and NJ Ex Order 26.4(b)(1)						
		•						
		rterly Minimum Data Set						
		nent tool, dated						
		e of which indicated that the						
	resident's cognition							
	A roviou of Desider	at #167's Dhusisian's arders						
		nt #167's Physician's orders ronic Medical Record (EMR)						
		or NJ Ex Order 26.4(b)(1)						
		tablet to by given						
		ours as needed for Wexore and a read of the source of Wexore and the source of the sou						
		e a duration for use or stop						
	date.	r						
	A review of the Pho	rmacy Consultant Report,						
	dated							
	documentation: "Re	esident has a PRN (as						
		Ex Order 28.4(b)(1) as needed. PRN						
	duration of 14 days	ations should be ordered for a , then reassessed, reordered						
		on, scheduled routinely, or						
	discontinued. CMS	6 (Center for Medicaid Service)						
	14 Day Rule MEGA	RULE."						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	IPLE	CONSTRUCTION	(X3) DATE	E SURVEY PLETED
AND FLAN C	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	IG _		C	
		315524	B. WING			10/*	16/2024
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 18 CHURCH ROAD		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE CROSS-REFERENCED)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Continued From pa	ge 126	F 75	8			
	During an interview 3:57 PM, in the pres U.S. FOIA (b) (6) after 14 days, the p and would determin extended or discord stated that if the PF days, then there sho medical record. During an interview at 8:56 AM, the U.S. PRN order of NJ EX PRN order of NJ EX been time-limited for re-evaluated. He fu PRN NJ Exorder 26.4(b)(1) v a progress note in the rationale. A further review reverevealed that the re NJ EX Order 26.4(b) by mouth at bedtime. There was no evide resident's NJ Exorder 26.4(b) During an interview at 3:57 PM, in the p the USTON	with surveyor on 10/15/24 at sence of the survey team, the) stated that typically rovider would be contacted the if the medication should be tinued. The serve further RN was ordered beyond 14 ould be documentation in the with the surveyor on 10/16/24 . FOIA (b) (6)) stated the order 26.4(b)(1) should have or 14 days and then rther stated that when the vas continued, there should be he medical record with a iew of Resident #167's PO sident had an active order for)(1) give 1 tablet e for N Ex Order 26.4(b)(1). ence in the EMR that the was being monitored. with the surveyor on 10/15/24 resence of the survey team,					
	of the WEXOTORIZED Unit, Resident #358, WEXOT	0:43 AM, during the initial tour the surveyor observed and ^{NETCOTET} lying in bed. tion, the resident started ^{NETCOTET}					

Facility ID: NJ03015

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DEPAR CENTE	FORM	03/31/2025 APPROVED 0938-0391					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ° '		E CONSTRUCTION	Сом	E SURVEY PLETED
		315524	B. WING				C 16/2024
NAME OF	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD		
LAUREL	. BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 758	and stated NJ Ex Order 26.4 to have an NJ Ex Or discontinued it." A review of the Adm Resident #358 was diagnoses including and NJ E NJ Ex Order 26.4(b The surveyor review Physician OS Resident #358 was medications: A PO, dated N Excession Give 1 tablet by mo for NJ Ex Order 26. DATE. A PO, dated N Excession Give 1 tablet by mo A PO, dated N Excession Give 1 tablet by mo A PO, dated N Excession Give 1 tablet by mo A PO, dated N Excession	der 26.4(b)(1), and I don't know (b)(1) I was receiving efused Wexorder 26.4(b)(1). I was receiving efused Wexorder 26.4(b)(1), I was receiving efused Wexorder 26.4(b)(1) , but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, but not limited to, Wexorder admitted to the facility with g, for Wexorder 26.4(b)(1) Tablet Wexorder admitted to the facility with g, for Wexorder 28.4(b)(1) Tablet Wexorder admitted to the facility with g, for Wexorder 28.4(b)(1) Tablet Wexorder admitted to the facility with g, for Wexorder 28.4(b)(1) Tablet Wexorder	F 7	'58			

Event ID: UBXH11

Facility ID: NJ03015

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		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIDI	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ° ′			COMPLETED	
							С
		315524	B. WING			10/	16/2024
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)
PRÉFIX		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG	x	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
					DEFICIENCY)		
F 750		400					
F 758		-	F 7	58			
	A PO, dated	, for NJ Ex Order 26.4(b)(1)					
	Give 1 capsule by r	nouth two times a day for					
	NJ Ex Order 26.4(b)(1)						
	A PO, dated ^{NJ Ex Order 25.4}	, forNJ Ex Order 26.4(b)(1)					
) Give 💆 tablet by					
	mouth at bedtime for	orNJ Ex Order 26.4(b)(1)					
	•						
		nt #358's admission MDS,					
	dated MEX out of 1	Ided the resident had a BIMS					
	resident's cognition	5 which indicated the was we want the MDS further					
	revealed that the re						
	NJ Ex Order 26.4(b)(1)	and NJ Ex Order 26.4(b)(1)					
	medications and ha	ad not had any ^{IN Ex Order 28.4(b)(1)}					
		dent's ICCP, included a					
		^{# 25.40} "I use <mark>NJ Ex Order 26.4(b)(1)</mark> terventions that included:					
		report to physician PRN (as					
	needed) signs and	symptoms (s/sx) of					
		ed by NJ Ex Order 26.4(b)(1)					
	medication or wors	ening s/sx of ^{NJ Ex Order 28.4(b)(1)}					
		P included a focus, created					
		tiene did not include NUEX OTER 26.4(b)(1)					
	monitoring.	ntions did not include ^{N Ex order 25.4(b);}					
	-						
		le ICCP included a focus, use ^{NJ Ex order 28.4(b)(1)} medication,"					
	and interventions d						
	monitoring.						
		der x014(b)(1) notes, dated					
	revealed that reside						
	stated that his/her	was 'N Exorder 26 after being					

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	FORM	03/31/2025 APPROVED 0938-0391					
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .		COMPLETED	
		315524	B. WING				
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD		
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER					OUNT LAUREL, NJ 08054		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	ID PREFIX	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
F 758	Continued From no	no 120	F 7	- 0			
F 730		er new room. A low dose	F 7	58			
		to help with the Nextereord A					
	A review of the prog	gress notes, dated ^{N Exorder 26.4(}					
	through NJ Ex Order 26.4(b)(1, r	evealed a progress note date which included the					
	resident was N Ex Order 26	[*] his/her ^{NJ Ex Order 26.4(b)(1)} , that					
	refused to NJ Ex Order 20	s given, and the resident ^{6.4(b)(1)} or ^{NJ Ex Order 26.4(b)(1)} . The					
		⁹ that he/she was ^{NJ Ex order 26.4 ^{(4(b)(1)} and ^{NJ Ex Order 26.4(b)(1)} was}					
	ordered. No other of was noted in the pro-	documentation of N Ex Order 26.4(b)(1)					
	NJ Ex Order 26.4(b)(1) MAR	^{E NJEX ORDER 264(B) (1)} and S and TARs did not reveal any phitoring related to ^{NJEX ORDER 264(B)}					
		AM, the surveyor					
	interviewed LPN #3	who stated that when a					
		d on a new ^{NJ Ex Order 26.4(b)(1)} ™ monitoring would be					
	documented for 14	days every shift, either in the the MAR. LPN # 3 further					
	stated that the facili	ty does not do monthly					
		oring or daily ^{wexomer2640%} ents on long term use of					
	NJ Ex Order 26.4(b)(1) medic	ations. If the staff saw any ent's Nex Constraints then they					
	would notify the doo	ctor or U.S. FOIA (b) (6) and					
	have them seen by further stated that	the U.S. FOIA (b) (6) LPN#3					
	ordered as a PRN (as needed), such as Nexonarian or 14 days and would need a					
	stop date on the PC						
	On 10/15/24 at 10:5	52 PM, the surveyor					

Facility ID: NJ03015

						FORM	APPROVED	
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPL	E CONSTRUCTION	0MB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN O					PLETED			
		315524	B. WING				C 16/2024	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL BROOK REHABILITATION AND HEALTHCARE CENT					718 CHURCH ROAD IOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE	
TAG F 758	Continued From par interviewed the LPN new WEXORE 26.4(0)(1) m resident's WEXORE 26.4 changed, then a 14 would be completed confirmed that a ne have a 14 day durat order. The WEXORE 26.4(0) documented in the The LPN/UM #3 sta conduct WEXORE 26.4(0) documented in the The LPN/UM #3 sta conduct WEXORE 26.4(0) medications. When U.S. FOIA(b)(6) would resident was preser U.S. FOIA(b)(6) would for medications were on notes, and would di During an interview at 3:57 PM, in the p the U.S. FOIA (b) (6) utilized a batch order orders for WEXORE 26.4(0) documented on the On 10/15/24 at 3:45 US FOIA(0)(6) the U.S. FOIA pO for PRN WEXORE 26.4(0) date on the order. 4.) On 10/9/24 at 9: PM, the surveyor of	ge 130 V/UM #3 who stated that if a hedication was ordered or a implications were -day implications of the MAR. asked how the US FOIA (b) (6) or know what implications were -day implications	F 7	58	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE	
		oserved Resident #40 in resident did not display any						

If continuation sheet Page 131 of 171

		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		COMPLETED	
		315524	B. WING				16/2024
NAME OF F	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Continued From pa NJ Ex Order 26:401 that tim A review of the Adm Resident #40 was a diagnoses including The surveyor review Physician Ord which reflected that following NJ Ex Order 26:4(b); Give 1 tablet NJ Ex Order 26:4(b)(1) A review of the resid MDS, dated NJ Ex Order 26:4 NJ Ex Order 26:4(b)(1) A review of the resid MDS, dated NJ Ex Order 26:4 NJ Ex Order 26:4(b)(1) A review of the resid MDS, dated NJ Ex Order 26:4 NJ Ex Order 26:4(b)(1) A review of the resid MDS, dated NJ Ex Order 26:4 NJ Ex Order 26:4(b)(1) A review of the resid MDS, dated NJ Ex Order 26:4 NJ Ex Order 26:4(b)(1) A review of the resid MDS fur was on an NJ Ex Order 26:4 NJ Ex Order 26:4(b)(1) A review of the resid MDS fur was on an NJ Ex Order 26:4 NJ Ex Order 26:4 N	ge 131 ne. hission Record revealed that admitted to the facility with y, but not limited to [**E**********************************	F 75	58		RIATE	
	USE NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) disorder	medication related to r." The interventions did not ring of target					

		AND HUMAN SERVICES			F	FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION		X3) DATE	E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		COM	
		315524	B. WING				16/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3718 CHURCH ROAD	E		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENT	ER	MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	HOULD B		(X5) COMPLETION DATE
TAG	REGULATORT OR E		IAG	DEFICIENCY)	- NOF RE		
F 758	Continued From pa	ge 132	F 75	58			
		iatrist note, dated Metodere,					
	revealed that the re and ^{NJEX Order 28.4(b)(1)} and	sident has a history of ^{N Ex order 26.4} d had been on <mark>NJ Ex Order 26.4(b)(1)</mark>					
	twice a day (BID) fo						
		37 AM, the surveyor interview					
	currently on NJ EX Order 25	that Resident #40 was and wexceed but had no change					
		lately. LPN #3 stated that ot have any ^{NEXCOME 204(D)}					
	monitoring and if th	ere were any changes in the					
	written in the progre	a ^{NUEX order 28.4(b)(1)} note would be ess note and the ^{NUEX order 28.4(b)(1)}					
	would be notified. L importance of	PN #3 stated that the monitoring was to see if					
		d an increase or decrease in					
		52 AM, the surveyor					
	#40 was not on any	M #3 who stated that Resident monitoring, his/her					
		NJ Ex Order 26.4(b)(1) r medication had not been					
	adjusted in "a while	." LPN/UM #3 confirmed that onitoring documentation in the					
	EMR was NJ Ex Order 26.4						
	A review of Resider	nt #40's progress notes dated					
	documentation of						
		ter 2 NJ Ex Ordel NJ Ex Order 26.4(t NJ Ex Order 26.4(b)(1)					
	any PO for targeted	MARs and TARs did not reveal					
	to ^{NJ Ex Order 26.4} Or ^{NJ Ex Order}	28.4(b)(1)					
	5.) On 10/9/24 at 12	2:36 PM, the surveyor					

						FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	(IPLE (CONSTRUCTION		
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG			
		315524	B. WING _				
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		8 CHURCH ROAD DUNT LAUREL, NJ 08054		
(X4) ID			ID	,	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
F 758	Continued From pa	ge 133	F 75	58			
		#17 lying in bed. The resident				COMPLETED C 10/16/2024 CITY, STATE, ZIP CODE AD ., NJ 08054 ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE	
	had diagnoses which	hission Record, Resident #17 ch included, but were not					
	limited to, <mark>NJ Ex Or</mark>	der 26.4(b)(1) , ^{NJ Ex} order 2 NJ Ex Order 26.4(b)(1)					
	, and ^{NJ Ex Or}	der 26.4(b)(1)					
		nission comprehensive					
		(MDS), an assessment tool, led the resident had a Brief					
	Interview for Menta	Status score of sout of 15,					
		resident's cognition was ew of the MDS revealed the					
		^{#der 26.4(b)(1)} and received I Ex Order 26.4(b)(1) medications					
	(types of NJ Ex Order 26.4(1						
	A review of the ICC	P, initiated ^{NJ Ex Order 26.4(b)(1} , included					
	and NJ Ex Order 26.4(b)(1	NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), Medications (NJ Ex Order 26.4(b)(1)					
	medications) with in effectiveness and s	terventions to "observe for ide effects."					
	A review of the Ord	er Summary Report (OSR),					
	with active orders a following physician	s of wexcounted the sorders:					
	NJ Ex Order 26.4(
	day for ^{NJ Ex Order 26.4(d)} -NJ Ex Order 26.4(b)(1) b	by mouth at bedtime for NECORERS					
	-NJ EX OTGET 20.4(D)(T) NJ Ex Order 26.4(b)(1)	by mouth at bedtime for					
		Medication Administration aled the following physician's					
	orders:						

Facility ID: NJ03015

DEPART	FORM	APPROVED						
	CS FOR MEDICARE	& MEDICAID SERVICES	(X2) MULT					
	F CORRECTION	IDENTIFICATION NUMBER:	1 ° '					
						(C	
		315524	B. WING			10/	16/2024	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD			
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		OUNT LAUREL, NJ 08054			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETION DATE	
					DEFICIENCY)			
F 758	Continued From pa	ne 13/	F 7					
1750	-NJ Ex Order 26.4(-	F /:	00		CTION (X5) DULD BE COMPLETION		
) by mou	uth once a day for NJ Ex Order 28.4(b)(1)						
	with order dates of	NJ Ex Order 26.4(b)(1 NJ Ex Order 26.4(b)(1 NJ Ex Order 26.4(b)(1						
	-	by mouth at bedtime for MEXOTHER						
	with order	dates of NJ Ex Order 26.4(b)(1) - NJ Ex Order 26.4(b)(1)						
	NJ Ex Order 26.4(b) ¹ - Ongoing.							
	-NJ EX Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) with order	by mouth at bedtime for r dates of ^{Nexoner254(b)t} - ^{Nexoner254(b)t} ;						
	NJ Ex Order 26.4(b)(¹ - ongoing.							
	-NJ Ex Order 26.4(b)(1) by mouth twice a						
	day for with ongoing.	order dates of Networker464(0)						
	ongoing.							
		he ^{NJ Ex order} through NJ Ex Order 26.4(b)(1)						
	to monitor target	re were no physician's orders						
	NJ Ex Order 26.4(b)(1) medic	ation use prior to NEX OTHER 264(D)(1						
	Duning on interview	with the component $\frac{10}{4}$						
		with the surveyor on 10/15/24 ed Nursing Assistant (CNA) #2						
	stated that if a resid	dent had NJEX Order 28.4(b)(1) the CNA						
		rse and come back later to						
		care. The CNA further stated ot have any ^{NJEx Order 28.4(b)(1)}						
		with the surveyor on 10/15/24						
		sed Practical Nurse (LPN) #4 A (b) (6) was supposed to						
	evaluate residents	monthly related to NJ Ex Order 25.4(b)(1)						
		nedication use. When asked						
		sments were documented, the The LPN further stated it was						
	important to monito	r NJEX OTGET 25.4(b)(1) for residents who						
		medications for the						
		id "to see if there is any ent's status." The LPN added						
		lid not have any NJ Ex Order 28.4(b)(1)						
		-						

Facility ID: NJ03015

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES O							
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCT G			СОМ	E SURVEY PLETED
		315524	B. WING _				(10/1	C 16/2024
		TION AND HEALTHCARE CENTE	R	3718 CHURCH				
					REL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTIVE AC REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) Completion Date
F 758	During an interview at 12:09 PM, the U.) stated that for target VEX order 28:4(9) order and VEX order 28:4(9) be documented on stated she was uns evaluate residents in and VEX order 28:4(9)(1) m about Resident #17 resident had VEX order 29:4(9)(1) m about Resident #17 resident had VEX order 29:4(9)(1) m about Resident #17 resident had VEX order 29:4(1) of VEX order 29:4(9)(1) m about Resident 's MAR. important to monito received VEX order 29:4(1) effectiveness and s During an interview at 3:57 PM, in the p the U.S. FOIA (b) (0 utilized a batch order orders for NJ EX Or stated that NJ EX O documented on the During a follow-up i 10/16/24 at 10:43 A Should h Resident #17 when medications were s 6.) On 10/9/24 at 11 observed Resident A review of the Adm summary) reflected diagnosis that inclu	with the surveyor on 10/15/24 S. FOIA (b) (6) tresidents being monitored would have a physician's or lack of WEXORE 284(0)(1) would the MAR. The US FOIA (0)(0) further ure who was supposed to monthly related to WEXORE 284(0)(1) redication use. When asked () (S FOIA (0)(0) was unsure if the or (0) but the WEXORE 284(0)(1) or lack d have been documented on . The US FOIA (0)(0) added that it was r WEXORE 284(0)(1) for residents who over the surveyor on 10/15/24 or sence of the survey team, (0)) stated the facility er set to create physician's der 26.4b1. The WEXORE 264(0)(1) medications stated the facility er set to create physician's der 26.4b1 should be MAR every shift. Interview with the surveyor on M, the WEXORE 264(0)(1) NEXORE	F 75	8				

Facility ID: NJ03015

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		315524	B. WING				C 16/2024
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER	-	718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 758	NJ Ex Order 26.4(b)). A review of the ann Data Set (MDS), ar Data Set (MDS), ar Mathematical Status so indicated NJ Ex Order review in Section N resident was on an A review of the Ord dated as of MEX Order 20.4 physician's order (F -A PO dated MEX Order 20.4 physician's order (F -A PO dated MEX ORDER 20.4 (N) Ex Order 2	ual comprehensive Minimum assessment tool, dated eresident had a Brief Interview core of or out of 15, which der 26.4(b)(1) . Further - Medication included: the NJ EX Order 26.4(b)(1) medication. er Summary Report (OSR) , included the following O(): ************************************	F 7	758			
	A review of the resid	dent's Individual					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG.			PLETED
		315524	B. WING _			10/1	5 16/2024
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Comprehensive Ca focus, revised demonstrate verbal created interventions in exercise 204000 Progress the following: On 7/4/24 at 9:58 P asses off 10 Ex order 204000 med management/risk a (effectiveness/moni During an interview at 1:07 PM, License Manager (LPN/UM NJ Ex Order 26.4(b)(1) w would try to NJ Ex Order 26.4(b)(1) w	A the U.S. FOIA (b) (6) sees the resident and checked tication requiring seessment	F 7	58			

		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES			E CONSTRUCTION		
	F CORRECTION	IDENTIFICATION NUMBER:	l` '		ECONSTRUCTION		
				-		(c
		315524	B. WING			10/	16/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF		DATE
					DEFICIENCY)		
F 758		-	F 75	58			COMPLETION
		monitoring, but that the t behaviors. He further stated					
		JEX Order 26.4(0)(1) they would be seen					
	more frequently.						
	A review of the facil	lity's "Psychotropic Medication					
		07/2022, included,					
	"Residents on psyc	hotropic medications receive					
	gradual dose reduc						
		al interventions), unless cated, in an effort to					
		nedications." Further review of					
		"Psychotropic medications					
		or given on a PRN basis tion is necessary to treat a					
		condition that is documented					
	in the clinical record	d," and, "PRN orders for					
		ations are limited to 14 days."					
		uded, ""Psychotropic ement includes: adequate					
	monitoring for effica						
		d, "Consideration for the use					
		medication is based on					
		iew of the resident. This of the resident's signs and					
		to identify underlying causes."					
		ty's "Behavioral Assessment,					
		onitoring" policy, revised "When medications are					
	prescribed for beha						
		include: specific target					
		ected outcomes; monitoring					
		verse consequences." Further included, "If the resident is					
		altered behavior or mood, the					
		y team] will seek and					
	document any impr	ovements or worsening in the					

Facility ID: NJ03015

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			MAPPROVEI D. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY
		315524	B. WING	1	C)/ 16/2024
				STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD	
LAUREL		TION AND HEALTHCARE CENTE		MOUNT LAUREL, NJ 08054	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 758	· · ·	ge 139 r, mood, and function."	F 758	3	
	NJAC 8:39-27.1(a) NJAC 8:39-29.2(d) Free of Medication CFR(s): 483.45(f)(1	Error Rts 5 Prcnt or More	F 759		11/21/24
	§483.45(f) Medicati The facility must en				
	percent or greater;	cation error rates are not 5			
	Based on observation other facility docum that the facility failer medications were a rate of 5% or less. I observation on 10/9 observed four nurse four residents. The errors which calcula	administered without an error During the medication pass 0/24 at 8:21 AM, the surveyor es administer medications to re were 32 opportunities and 2 ated to a medication		1. Resident #92 was evaluated by a Registered Nurse with WEX Order 26.4(b)(1) related to cited event. Resident #92's Clinical Provider and RP were made aware. No new orders were obtained. LPN #2 was re-educated by Assistant Director of Nursing on 10/21/24 the facilit medication administration policy, signing for medication after administration, process when a medication is not available on the cart and medications tha	У
	administration error rate of 6 This deficient practice was ic residents (Resident #92) and the following:	ice was identified for 1 of 4 t #92) and was evidenced by		should not be crushed. A medications that competency was also completed for LPN #2 2. Current residents have the potential t	
	Licensed Practical I labeled medications (medic over the counter with placed the medicately affi	AM, the surveyor observed Nurse (LPN) #2 obtain a bottle om the supply of house stock cation that can be obtained thout a prescription). The LPN capsule in a medication cup ter, documented on the stration Record (MAR) that the		be affected by the cited occurrence. An audit was completed on residents with orders for Ascorbic Acid to validate that the medication was available and on han in the medication cart for administration. In addition, an audit of residents on Oxybutin Chloride ER was completed to validate the residents did not require ther	d

Facility ID: NJ03015

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		AND HUMAN SERVICES				03/31/202 APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	TIPLE CONSTRUCTION	_ Сом	E SURVEY PLETED
		315524	B. WING			_ 16/2024
NAME OF	PROVIDER OR SUPPLIER	L	·	STREET ADDRESS, CITY, ST		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENT	ER	3718 CHURCH ROAD MOUNT LAUREL, NJ 0	08054	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) Completion Date
F 759	medication was adr all the resident's me all the resident's co and LPN #2 confirm the medications we going to administer LPN was asked if NEX order 204(D)(1) order further stated, that y house stock medica it is ok." A review of the Phy an active order for me, the resident d NEX Order 204(D)(1) with a s time, the resident d NEX Order 204(D)(1) with a s time, the resident d NEX Order 204(D)(1) with a s time, the resident d NEX Order 204(D)(1) The surveyor contin stated, when a hous was empty she cou go to the backup su When asked did sh room today (10/9/24 then stated she also supply for the medic explained this was for NEX Order 204(D)(1). During an interview at 10:55 AM, the LF for when a medicat medication cart, wa pharmacy immedia an estimated time of	age 140 ministered. The LPN gathered edications, including the eyor asked the LPN if she had rrect medications in the cup ned with the surveyor that all re correct and that she was the medications. When the every was the same as the ed, she replied "yes" LPN #2 was what they had in their ation, and "central supply said sician Orders (PO) there was NJEX Order 20.4(b)(1) e time a day at 9:00 AM for start date of etime a day at 9:00 AM for start date of etime a day at 9:00 AM for start date of etime a day at 9:00 AM for start date of etime an order for a hued to interview LPN #2 who se stock bottle of medication and go to the central supply or upply in the medication room. the check the medication supply 4), she replied "no." LPN #2 o did not check with central cation today (10/9/24), She her first resident with an order with the surveyor on 10/10/24 PN/UM #1 stated the process ion was not available in the tes she would contact the tely to get an explanation for of arrival (ETA) or any s to why the medication did not	F7	the facility medicati policy, signing for m administration, proc medication is not av medications that sh Staff education incl the 2567 4. The DON/desig audit on 3 residents Ascorbic Acid to va medication was ava the medication cart addition, an audit of Oxybutin Chloride E validate the residen have their medication Variances will be ac will be conducted w monthly x 2 months audits will be subm	ed. ted licensed nurses on on administration nedication after cess when a vailable on the cart and nould not be crushed. uded those identified in gnee will conduct an s with orders for lidate that the ailable and on hand in t for administration. In f 3 residents on ER will be completed to nts did not require or ons crushed. ddressed. These audits veekly x 4 weeks, then s. The findings of the itted by the Director of PI Committee for review on monthly for 3	

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED 315524 B. WING 10/16/2024	RVEY
A. BOILDING C	20
315524 B. WING 10/16/2024	
	024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD	
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER MOUNT LAUREL, NJ 08054	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	(X5) IPLETION DATE
 F 759 Continued From page 141 arrive. She explained that way they could notify the physician if there needed to be a one time orders or an adjustment for that medication. LPN/UM#1 stated that the automated medication dispensing machine would be checked first to see if it was available. LPN/UM #1 confirmed that Wiccontention was a house stock medication. She stated. Thave never encountered one of our house stock meds (medications) not being available." During the same medication administration observation. LPN #2 removed an Wiccontent to the there is gradually released over time is tablet from the resident's medication packet. LPN #2 then place the Wiccontext U tablet in a plastic pouch and proceeded to crush the medication using the pill cruster. LPN #2 stated, the resident took their medications crushed. A review of the PO revealed Wiccontext (Diablet by mouth one time a day for Miccontext (Diablet by mouth one time a diablet (Diablet by mouth one time a diablet (Diablet by mouth one ti	

Facility ID: NJ03015

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		AND HUMAN SERVICES			C	FORM	: 03/31/2025 APPROVED : 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CON	E SURVEY IPLETED
		315524	B. WING				16/2024
	PROVIDER OR SUPPLIER	TION AND HEALTHCARE CENTI	ER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 759	Continued From pa administration befo	ge 142 re giving the medication."	F	759			
	N.J.A.C 8:39-29.2(Label/Store Drugs a CFR(s): 483.45(g)(and Biologicals h)(1)(2)	F	761			11/21/24
	Drugs and biologica labeled in accordan professional princip appropriate access	g of Drugs and Biologicals als used in the facility must be ace with currently accepted oles, and include the ory and cautionary e expiration date when					
	§483.45(h)(1) In ac Federal laws, the fa biologicals in locked	e of Drugs and Biologicals cordance with State and acility must store all drugs and d compartments under proper ls, and permit only authorized access to the keys.					
	locked, permanenti storage of controlle the Comprehensive Control Act of 1976 abuse, except when package drug distri quantity stored is m be readily detected This REQUIREMEN	facility must provide separately y affixed compartments for d drugs listed in Schedule II of e Drug Abuse Prevention and and other drugs subject to n the facility uses single unit bution systems in which the ninimal and a missing dose can NT is not met as evidenced					
	pertinent facility doo determined that the dispose of expired	tion, interview, and review of cumentation, it was a facility failed to properly medical equipment and sanitary medication storage			1. No specific residents were ide East Medication Storage room- or 10/10/24 the RN/UM discarded the identified box of Shiley inner cann containing 10 expired cannulas.	n e	

Facility ID: NJ03015

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ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION	OMB NO.	E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	1 ° ′			PLETED
						0
		315524	B. WING			- 16/2024
AME OF F	PROVIDER OR SUPPLIER	I	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		
				3718 CHURCH ROAD		
AUREL	BROOK REHABILITA	ATION AND HEALTHCARE CENTI	=R	MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) Completio Date
F 761	Continued From pa	ge 143	F 76	51		
	-	nt practice was observed in 2		North 1 Medication Storage ro	om- on	
	of 3 medication sto	rage rooms and 1 of 5		10/10/24 the LPN/UM #1 disca	arded the	
		viewed for medication storage		identified expired tracheostom		
	and labeling and wa	as evidenced by the following:		the Two (2) gastrostomy feedin		
	$O_{\rm P}$ 10/10/24 at 0.2	1 AM the survey or in the		and the One (1) VAD access k addition, the 13 unidentifiable		
	presence of the U.S	1 AM, the surveyor, in the		noted on the bottom cart of un		
		the East Medication Storage		medication cart were appropria		
		ined one (1) box of Shiley		discarded and the cart was cle		
		lastic medical tube which is		Expired items and medications	lications were	
		dent's tracheostomy (an		replaced as indicated.		
		into the windpipe to help a		2. An audit was completed m		
	with an expiration d	ntaining 10 expired cannulas		storage rooms and medication the Unit Mangers/designee 10		
	with an expiration of	late 01 5/25/24.		validate the facility medication	11/24 10	
	On 10/10/24 at 10:0	07 AM, the surveyor, in the		storage/medical equipment po	licv was	
		ed Practical Nurse Unit		followed to include removal an	d proper	
		JM #1) observed the North		disposition of expired medical	equipment	
		medication storage room in		and removal and appropriate of		
	which the following	expired items were identified:		loose pills in the medication ca	irt. No	
	One (1) tracheostor	my care tray expired 9/10/23		further variances were noted. 3. The DON/designee re-edu	loated	
		iy (an opening into the		licensed nurses on the facility		
		abdominal wall, made		storage/medical equipment po		
		troduction of food.) feeding		include removal and proper dis		
	tube one expired or	n 12/26/2023 and one expired		expired medical equipment an	d removal	
	11/6/2023			and appropriate disposal of loc	ose pills in	
		s kit (a set of tools used to		the medication cart.		
	system) expired 8/3	into a patient's vascular 31/24		Staff education included those the 2567		
	On 10/10/24 at 10:4	45 AM, the surveyor, in the		 The DON/designee will co rounds to validate the facility n 		
		ered Nurse #1 (RN #1),		storage/medical equipment po		
		One nursing unit's B		followed to include removal an		
		ich contained 13 unidentifiable		disposition of expired medical		
		s shapes, colors, and sizes in		and removal and appropriate of	lisposal of	
	the bottom of cart of	lrawers.		loose pills in the medication ca		
				Variances will be addressed. T		
	AT THIS TIME, KN #1	informed the surveyor that		will be conducted weekly x 4 w	eeks, then	

Facility ID: NJ03015
		AND HUMAN SERVICES	-			FORM	03/31/202 APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		NSTRUCTION	COM	E SURVEY IPLETED
		315524	B. WING				0 16/2024
	PROVIDER OR SUPPLIER	TION AND HEALTHCARE CENTE	ER	3718 0	ET ADDRESS, CITY, STATE, ZIP CODE Church Road NT Laurel, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	۲ ۱	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 761 F 791 SS=E	there should not ha medication cart. On 10/10/24 at 1:50 the U.S. FOIA (b) (0 there should not ha the medication stor should be no loose A review of the facil Labeling and Storag limited to: "the nurs maintaining medica areas in a clean, sa facility has discontin medications or biolo pharmacy is contac returninf or destroy N.J.A.C. 8:39-29.4 Routine/Emergency CFR(s): 483.55(b)(1) §483.55 Dental Ser The facility must as routine and 24-hour §483.55(b) Nursing The facility- §483.55(b)(1) Must outside resource, ir of this part, the follo the needs of each r	ve been any loose pills in the D PM, the surveyor interviewed D PM, the surveyor interviewed page areas and that there pills in the medication carts. Ity's undated "Medication ge" policy included but was not ing staff is responsible for tion storage and preparation afe, and sanitary manner. If the nued, outdated, or deteriorated ogicals, the dispensing ted for instructions regarding ing these items." y Dental Srvcs in NFs 1)-(5) vices sist residents in obtaining r emergency dental care. Facilities. provide or obtain from an n accordance with §483.70(f) owing dental services to meet resident: ervices (to the extent covered n); and	F 76	ma au Nu an ma su	onthly x 2 months. The findings idits will be submitted by the Dire ursing to the QAPI Committee for d recommendation monthly for onths or ongoing until compliance stained.	ector of or review 3	11/21/24

Facility ID: NJ03015

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		AND HUMAN SERVICES	-			FORM	03/31/2025 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315524	B. WING				
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENT	ER		718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 791	§483.55(b)(2) Must assist the resident- (i) In making appoin (ii) By arranging for dental services local §483.55(b)(3) Must residents with lost of dental services. If a 3 days, the facility r what they did to en- and drink adequate services and the ex- led to the delay; §483.55(b)(4) Must circumstances whe dentures is the faci charge a resident for dentures determine policy to be the faci §483.55(b)(5) Must eligible and wish to reimbursement of of medical expense un This REQUIREMEN by: Based on observat and review of other was determined that necessary	a, if necessary or if requested, htments; and transportation to and from the ations; promptly, within 3 days, refer or damaged dentures for a referral does not occur within must provide documentation of sure the resident could still eat thy while awaiting dental tenuating circumstances that the loss or damage of lity's responsibility and may not or the loss or damage of ed in accordance with facility lity's responsibility; and assist residents who are participate to apply for dental services as an incurred nder the State plan. NT is not met as evidenced tion, interviews, record review, pertinent documentation, it at the facility failed to provide are services in a timely esident (Resident #143)	F	791	1. Resident #143 had a completed on with ordered. Resident #143 is aware satisfied with the resolution and t grievance updated 2. Current residents have the p be affected by cited occurrences was completed of residents that dentures or have missing denture completed to validate that provise	and he otential to . An audit utilize es was	
	following:	ice was evidenced by the 6 AM, during the initial tour of			was completed of residents that	utilize es was ion of	

Facility ID: NJ03015

CENTE STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. (FORM MB NO. (X3) DATE COM	03/31/2025 APPROVED 0938-0391 E SURVEY PLETED
		315524	B. WING			10/*	16/2024
LAUREL				3	TREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD NOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 791	the facility the survey lying in bed awake bedside. The reside ordered a NJ Ex Of The resident furthe a """"" ago was going to replace happened". A review of Resider admission summar was admitted to the included but were r), NJ Ex Ord (), and NJ Ex Of (), and	eyor observed Resident #143 with a visitor present at the ent stated that he/she was rder 26.4(b)(1)). r stated, "I lost my vector 204 and thought that the facility be them, but it never and thought that the facility be them, but it never and thought that the resident e facility with diagnosis which not limited to: vector 204(0)(1) Prevealed that the resident e facility with diagnosis which not limited to: vector 204(0)(1) Prevealed that the resident e facility with diagnosis which not limited to: vector 204(0)(1) Prevealed that the resident e facility with diagnosis which not limited to: vector 204(0)(1) Prevealed that the resident e facility with diagnosis which not limited to: vector 204(0)(1) Prevealed that the resident e sector 100 million of the sector 204(b)(1) or def 26.4(b)(1) or def 26.4(b)(1) e state resident was vector 204(0)(1) e state reside	F 7	791	indicated. Variances were addresse Completed on 10/17/24 by Director Nursing/Designee. 3. The Administrator/ designee re-educated the Social Workers an Licensed nurses on timely follow up regarding dental care services, noti resident of appointments or resolut notification to Administrator and/or with barriers. Staff education included those iden the 2567 4. The Director of Social Services/designee will conduct 3 au residents that utilize dentures or ha missing dentures was completed to validate that provision of dental car services was completed in a timely manner to include documentation of follow-up/resolution. Variances will addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of audits will be submitted by the Direct Nursing to the QAPI Committee for and recommendation monthly for 3 months or ongoing until compliances sustained.	of d the fying ion and DON tified in udits of ve e of be f the ctor of review	

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT				0938-0391
	F CORRECTION	IDENTIFICATION NUMBER:	1 ° '		ECONSTRUCTION		PLETED
							c
		315524	B. WING			10/1	6/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD		
LAUREL	AUREL BROOK REHABILITATION AND HEALTHCARE CENTER MOUNT LAUREL, NJ 08054						
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	-	(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
F 791	Continued From pa	ao 147	F 70				
1 / 51	Continued From pa	ge 147	F 79	91			
	A review of a	Therapy Treatment					
		dated Nexoneras revealed, "Pt					
	(treatment)NJ Ex	droom for ^{NJ Ex Order 26.4(b)(1)} tx. Order 26.4(b)(1)					
	given partial NJ Ex	Order 26.4(b)(1) , yet					
		alA second entry dated J Ex Order 26.4(b)(1)					
	assisting	pt to insert NJ Ex Order 26.4(b)(1)					
	pt still awaiting ^{NJ Ex or}	der 26.4b1 NJ Ex Order 26.4(b)(1)					
	On 10/9/24 at 9:45	AM, the surveyor requested to					
		residents who had filed					
		bursement of missing items.					
	that the resident wa	wed the list provided and noted as not on the list.					
		with the surveyor on 10/9/24 rveyor interviewed Licensed					
		t Manager (LPN/UM) #1 who					
	stated that if a resid	lent reported a missing item					
		arched for the item with . LPN/UM #1 stated that if the					
		, she reached out to					
	housekeeping and	dietary and all parties were					
		JM #1 stated that Social Work id we started an investigation					
	process.	iu we starteu an investigation					
	0- 40/0/04 - 140 54						
		I PM, the surveyor observed in bed with their meal tray in					
	front of them. The r	esident stated that he/she					
		Order 26.4b1 to the U.S. FOIA (b) (*					
	made.	recall when the report was					
		with the surveyor on 10/9/24 S. FOIA (b) (6) stated that when					
	someone lost their						

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		315524	B. WING_				C 16/2024
NAME OF	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) Completion Date
F 791	into the portal and a housekeeping and t the grievance to the not found. The U.S. was a grievance file on "Percent and sta was filed it went to a matter was discuss "was present and sta was filed it went to a matter was discuss "was any follow up." she spoke with the mentioned that he/s replaced due to "Per- she communicated and the UST FOIA (O)(0). If she even filed on "Percent asked asked the U.S. FOIA the resident asked missing "Percent asked missing" and At that time, the "	assigned it to both the laundry and then rerouted e business office if they were FOIA (b) (6) stated that there ed on behalf of Resident #143 he residents [Nercourse of were FOIA (b) (6) ated that once the grievance everyone's email and the ed in morning meeting. The e did not remember if there The U.S. FOIA (b) (6) stated that resident yesterday and he/she she wanted their [Nercourse of the she wanted the U.S. FOIA (b) (6) The surveyor asked the [Nercourse followed up with the grievance ior to yesterday and she e resident brought it up to her rmed the resident that the sting for them. The surveyor (b) (6) if she documented when about the status of his/her nd she stated, "No".	F 7	91			

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		AND HUMAN SERVICES						APPROVED
		& MEDICAID SERVICES						0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '		E CONSTRUCTION	(X3	COMF	E SURVEY PLETED
		315524	B. WING				C 10/1	16/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL	BROOK REHABILITA	ATION AND HEALTHCARE CENTE	ICARE CENTER 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	C	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE		(X5) COMPLETION DATE
F 791	During an interview at 11:05 AM, the U. stated that she had	NJ Ex Order 26.4(b)(1), that was or inquiry. with the surveyor on 10/10/24	F 75	91				
	email was sent that grievance has been department." The should live in the sy may have been a d a grievance related stated that this hap another resident an the facility's liability from the resident's directly. The syesterday that Resi	t informed the recipient, "A n assigned to your stated that the grievance ystem historically, but there iscrepancy, as she did not see to Resident #143's missing not speak to that. The state pened fairly recently with and it was identified that it was and we received an invoice stated that she was informed ident #143's states were with the resident's spouse to						
	at 11:52 AM, the su U.S. FOIA (b) (6) stated that he was r Resident #143's gri was reportedly filed grievance was assi was sent out to all p responsible to drive moment. The USFORCE was well connected the grievance relate from NJ Ex Order 26.4(b)	with the surveyor on 10/10/24 inveyor interviewed the) who not the U.S. FOIA (b) (6) on record when ievance for NJ Ex Order 26.4b1 I. The ^{USFOACE} stated that a gned to a party, and an email parties, and the ^{USFOACE} was the investigation at that stated the communication d, but there was no answer on ed to the missing ^{MECCEPTICATION} (C). The ^{USFOACE} sated that he have thought that the ^{USFOACE}						

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '		E CONSTRUCTION	(X3) DAT	E SURVEY
AND FLAN	ORRECTION	IDENTIFICATION NOWDER.	A. BUILDI	NG .			C
		315524	B. WING			10/	16/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD				TREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD			
LAUREL	AUREL BROOK REHABILITATION AND HEALTHCARE CENTER MOUNT LAUREL, NJ 08054						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 791	US FOLADOTO grievance investiga U.S. FOLA (b) (c) The certainly a lapse an further stated that the follow up with the me have been taken can During an interview at 12:52 PM, the Lie Manager (LPN/UM) was set up to go an after se further stated that he resident reported the prior. During an interview at 10:51 AM, the U. stated that when a the missing and could re family to verify and consult with Second pay for the service if fault or the Service if appointment was service if at 2 consult for replacer A review of an unda	 The USECATE stated, The tion starts and stops with the stated, "There was d delay there." The USECATE stated, "There was d delay there." The USECATE stated, "There was d delay there." The USECATE was d delay there." The USECATE would are of. with the surveyor on 10/10/24 censed Practical Nurse/Unit and see the NECORET for NECORET and the stated that Resident #143 and see the NECORET for NECORET and the missing NECORET and the surveyor inquiry. LPN/UM #4 he did not think that the he missing NECORET and to him with the surveyor on 10/15/24 S. FOIA (b) (6) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c	F 7	91			

		AND HUMAN SERVICES				FORM	APPROVED	
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPI F		MB NO. 0938-0391 (X3) DATE SURVEY		
	FCORRECTION	IDENTIFICATION NUMBER:	1 ° '				PLETED	
		315524	B. WING					
NAME OF F	PROVIDER OR SUPPLIER	515524	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	10/	16/2024	
	LAUREL BROOK REHABILITATION AND HEALTHCARE CEN				18 CHURCH ROAD			
LAUREL		TION AND REALTHCARE CENTE		Μ	OUNT LAUREL, NJ 08054			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION	
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE	
	1		1	-	22. (012.10.1)			
F 791	Continued From pa	ge 151	F 79	91				
	Investigating" revea	led the following:						
	All grievances and	complaints filed with the facility						
		and corrective actions will be						
	taken to resolve gri	evances (s).						
	The administrator h	as assigned the responsibility						
	of investigating grie	vances and complaints to the						
	grievance officer.							
	Upon receiving a gr	ievance and complaint report,						
		r will begin an investigation						
	into the allegations.							
	The Resident Grid							
		t will be filed with the five (5) working days of the						
	incident.	inter (o) working days of the						
	The Pesident or pe	erson acting on behalf of the						
		rmed of the findings of the						
	- · · ·	Il as any corrective actions						
	recommended.							
		rts must be signed and will be						
	on behalf of the res	ne resident or person acting ident						
E 010	NJAC 8:39-15.1(b)		Го				11/01/04	
	CFR(s): 483.60(i)(1	Store/Prepare/Serve-Sanitary)(2)	F 81	12			11/21/24	
	§483.60(i) Food sat The facility must -	rety requirements.						
	-							
		ure food from sources ered satisfactory by federal,						
	state or local author							

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		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
						0
		315524	B. WING			16/2024
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
AUREL	BROOK REHABILIT	ATION AND HEALTHCARE CEN	TER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 812	Continued From pa	age 152	F 81	2		
	•	e food items obtained directly	1 01			
		rs, subject to applicable State				
	and local laws or re					
		oes not prohibit or prevent produce grown in facility				
		compliance with applicable				
		ood-handling practices.				
	(iii) This provision of	does not preclude residents				
Ę	from consuming fo	ods not procured by the facility	/.			
	8483 60(i)(2) - Stor	e, prepare, distribute and				
		dance with professional				
	standards for food					
		NT is not met as evidenced				
	by:	tion intensions and vestions of		1 No energific regidente u		
		tion, interview, and review of lity documents, it was		 No specific residents w In the refrigerator identified 		
		e facility failed to handle		" ^{NJ EX Order 25.4} " Refrigerator":	astric	
	potentially hazardo	us foods and maintain		The two sealed bags of coo	oked rice	
		and consistent manner to		identified were removed an	d discard by	
		illness. This deficient practice		the FSD on 10/8/24		
		e facility's kitchen and 5 of 5 nated for resident food, and		East unit pantry: The identified expired 20 si	nale servina	
	was evidenced by			size containers of cranberry		
				the 18 single-serving size of	•	
		9:30 AM to 10:45 AM, the		apple juice, one single-serv		
		nied by the <mark>U.S. FOIA (b) (6)</mark>		container of orange juice, a		
	the following:	red the kitchen and observed		single-serving size containe lactose-free milk were remo		
	the following.			discarded by the Food Serv		
	In the refrigerator i	dentified as the 'NEXOTOR 26.40		10/15/24.		
	Refrigerator":			The two blue reusable tote		
	1 Two analast horse	of applied the will a set by		containers of unlabeled, un		
		s of cooked rice with a use-by The two		were removed and discarde when. The refrigerator was		
		ator and discarded them.		include removal of the iden		
				liquid by who and when		
				Central unit:		
		36 AM, the surveyor,		A thermometer was place in		

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		AND HUMAN SERVICES	_			FORM	03/31/2025 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. 1			СОМ	E SURVEY PLETED	
		315524	B. WING			- C 10/16/2024		
NAME OF F	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP COL			
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENT	ER	I .	718 CHURCH ROAD NOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) Completion Date	
F 812	Continued From pa	ae 153	F	812				
	accompanied by the refrigerator designal East unit pantry: 1. Single-serving sit cocktail juice that h -01/2024 (1 contain -03/2024 (1 contain -04/2024 (1 contain -07/2024 (1 contain -08/2024 (3 contain -09/2024 (12 contain -10/05/24 (1 contain -00/2024 (2 contain -08/2024 (8 contain -08/2024 (8 contain -09/2024 (8 contain -09/2024 (8 contain -09/2024 (8 contain -09/2024 (1 contain	e U.S. FOIA (b) (6) observed the following in the ated for resident food in the ze containers of cranberry ad a use-by date of: er) er) er) er) ers) iners) ner) ze containers of apple juice of: ers) ers) ers) ers) ers) ers) ze containers of orange juice of: ers) ers) ers) ers) ers) ers) ers) ers)		012	refrigerator and a temperature posted to monitor refrigerator temperatures, the identified tw unlabeled, undated plastic be- one cup containing an opaque liquid, cup containing a clear, the expired single-serving size of vanilla yogurt and strawber were removed and discarded by Food Service Staff. West Unit pantry: The refrigerator was checked the Director of Maintenance a working order. The refrigerator temperature is set appropriate temperatures within range. The identified single-serving size container of creamy strawber the five single-serving size co apple juice, and the plastic wr peanut butter and jelly sandwi removed and discarded by the nurse. North 2 unit pantry: The identified single-serving si lactose-free milk was remove discarded by the Food Service 10/15/24 North 1 unit pantry:	vo verage cups, e white yellow liquid, e container ry parfait by 10/15/24 10/15/24 by ind is in or ely with size ry Glucerna, ntainers of apped ich were e licensed size fat-free d and		
	The the remove beverages. 5. Two blue reusable unlabeled, undated to the shelf of the re	ed and discarded the expired le tote bags with containers of food. One tote bag was stuck efrigerator and was leaking a			The identified two sealed cher the two unlabeled, undated pl beverage cups were removed discarded by Food Service sta 10/15/24 2. Current residents have th be affected by the cited occur	astic I and aff on e potential to rence. On		
		uid. The stated the stated the food brought in by visitors.			10/15/24 The Director of Food conducted rounds of the pant validate the Refrigerators wer	ry rooms to		

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		AND HUMAN SERVICES				FORM	03/31/202 APPROVEI 0938-039
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′			(X3) DATE COM	E SURVEY PLETED
		315524	B. WING	i			C 16/2024
NAME OF F	PROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTI	ER		18 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) Completion Date
F 812	During an interview stated she was uns maintain the unit part On 10/15/24 at 10:4 accompanied by Lid #1, observed the for designated for resid 1. There was no the refrigerator, nor a te outside of the refrig temperatures. 2. Two unlabeled, up that were covered was an opaque white lid contained a clear, y 3. A single-serving and strawberry part 10/02/24. During an interview she would discard to was not sure who we the refrigerator. At that time, Licens Manager (LPN/UM)	at that time, the USE OAT (510) sure who was supposed to antry. 48 AM, the surveyor, censed Practical Nurse (LPN) forming in the refrigerator dent food on the Central unit: ermometer inside the emperature log posted on the perator to monitor refrigerator andated plastic beverage cups with a lid. One cup contained puid, and the other cup	F	312	food were dated, labeled and with by dates. Review also validated the refrigerator had thermometers, and temperatures were taken and with range. Variances were addressed 3. The Director of Food Service/designee re-educated die nursing staff on the facility food procurement, storage, preparation serve-sanitary policies that include labeling and dating of food discard expired items, temperature monits and cleanliness of refrigerators. The process of staff assigned to monit pantry area and refrigerators for compliance was also reviewed. Staff education included those identified the 2567 4. The Director of Food Services/designee will complete 3 of the pantry rooms to validate the Refrigerators were cleaned, food dated, labeled and within use by of The review will also validate those refrigerators had thermometers, and temperatures were taken and with range. Variances will be addressed These audits will be conducted we weeks, then monthly x 2 months. findings of the audits will be submation the Administrator to the QAPI Cor	hat ad that ad that ad that an tary and an and es ding oring The tor entified in B rounds ewas dates. ad ad that ad ad that ad ad that ad t	
	PM - 11:00 PM and nurses were respon refrigerator tempera On 10/15/24 at 10:5 accompanied by LF	hisplaced," and that the 3:00 11:00 PM - 7:00 AM shift hsible for checking the atures. 57 AM, the surveyor, PN/UM #2, observed the igerator designated for			for review and recommendation n for 3 months or ongoing until com is sustained.	-	

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	CORRECTION	DENTIFICATION NOMBER.	A. BUILDIN	NG			
		315524	B. WING			10/ [.]	16/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		OUNT LAUREL, NJ 08054		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) Completion Date
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DAIL
F 812	Continued From pa	ae 155	F 81	12			
	resident food in the	-		-			
		of the refrigerator was 22					
	degrees Fahrenheit refrigerator thermos	t. The ^{U.S. FOIA (b) (6)} adjusted the stat.					
		size container of creamy a (nutritional supplement) that					
	was in the back of t	he refrigerator and frozen. ed the supplement to discard.					
	juice that had no us	ng size containers of apple se-by date. LPN/UM #2 containers to discard.					
	sandwich that had a	d peanut butter and jelly a use-by date of 10/11/24. ed the sandwich to discard.					
	stated the nurses w	at that time, LPN/UM #2 vere responsible for t pantry and refrigerator					
	accompanied by LF following in the refri	08 AM, the surveyor, PN/UM #3, observed the gerator designated for North 2 unit pantry:					
		size fat-free lactose-free milk of 10/12/24. LPN/UM #3 o discard.					
	stated housekeepin	at that time, LPN/UM #3 og maintained the unit pantry onitors the refrigerator					
	On 10/15/24 at 11:1	9 AM, the surveyor,					

		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD			Сом	E SURVEY PLETED
		315524	B. WING				C 16/2024
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 812	accompanied by LF following in the refri resident food in the 1. Two sealed cheed date. LPN/UM #1 s have belonged to si the refrigerator to d 2. Two unlabeled, ut that were covered w freezer portion of th frozen liquids. LPN belonged to staff ar During an interview stated the nursing s pantry. During an interview at 1:59 PM, the stated the nursing s pantry. During an interview at 1:59 PM, the stated the nursing s pantry. During an interview at 1:59 PM, the stated the state the since it would The storing their person designated for resid During an interview at 4:12 PM, the State since it would the storing their person designated for resid During an interview at 4:12 PM, the State since it would the storing their person designated for resid During an interview at 4:12 PM, the State since it would the storing the state since it would the state since s	PN/UM #1, observed the igerator designated for North 1 unit pantry: use sticks without a use-by stated the cheese sticks could taff, but removed them from iscard. Indated plastic beverage cups with a lid that were in the refrigerator and contained I/UM #1 stated the cups and left them in the freezer. That that time, LPN/UM #1 stated nursing staff maintained the unit with the surveyor on 10/15/24 stated nursing staff should it pantries for expired food and gerator temperatures daily. That that food brought in by abeled and dated with a use-by only be good for three days. That staff members should not be al food in the refrigerators done to the surveyor on 10/15/24 with the surveyor on 10/	F	312			

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		AND HUMAN SERVICES			FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING (X2) MULTIPLE CONSTRUCTION (X3) DATE SI COMPLE				SURVEY	
		315524	B. WING		(10/1	C 16/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	expired foods were storing personal foo refrigerators, and the were monitored. Review of the facilitic policy, revised 11/20 and/or freezers are condition. Refrigerat 41 degrees Fahrent foods solid," and, "M refrigerators and free temperatures." Fur included, "Supervise ensuring food items and freezers are no dates." Review of the facilitic Family/Visitors, und in by family/Visitors consume later will be manner that is cleant facility-prepared foo	discarded, staff were not od items in resident he refrigerator temperatures by's Refrigerators and Freezers 022, included, "Refrigerators maintained in good working ators keep foods at or below heit and freezers keep frozen Monthly tracking sheets for all eezers are posted to record ther review of the policy ors are responsible for s in the pantry, refrigerators, of past 'use by' or expiration by's Foods Brought by lated, included, "Food brought that is left with the resident to be labeled and stored in a rly distinguishable from od," and, "The nursing staff will	F 81	2		
F 835 SS=F	date." NJAC 8:39-17.2(g) Administration	foods on or before the 'use by'	F 83	5		11/21/24
	enables it to use its efficiently to attain o	dministered in a manner that resources effectively and or maintain the highest l, mental, and psychosocial				

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315524	B. WING			C 10/16/2024		
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENT			718 CHURCH ROAD IOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 835	This REQUIREMENT by: Based on observation pertinent facility do that the facility's U.S. implemented facility ensure a.) residents services to achieve wellbeing, and b.) menvironment, equip safe, sanitary, and deficient practice we nursing units, and we following: Refer to F584, F644 F812 A review of the U.S. provided by the fact The U.S. FOIA (b) (6) the day-to-day funct accordance with cut standards, guideling nursing centers to a of quality care can be all times. Duties and Respon- limited to: plan, develop a and procedures and	NT is not met as evidenced tions, interviews, and review of cuments, it was determined	F 8	35	 For specific resident correction to F584, F645, F657, F689, F758 F812 for full plan of correction. Current residents have the policities and review refer to F645, F657, F689, F758, and F87 plan of correction. The facility U.S. FOIA (b) (6) and was re-educated by the Vice Press Clinical Operations on the Facility Administrator duties as outlined in job description and regulatory gui for Administration which includes not limited to the need to validate implementation of facility policies procedures by staff to promote re- provision of care and services to their highest practical wellbeing, a maintain the resident environment equipment and living areas in a si- sanitary, and homelike manner. Staff education included those identify the 2567 For specific ongoing audits and review refer to F584, F645, F657, F758, and F812 for full plan of co A consultant Administrator and a consultant DON were hired and b services 40 hours a week on 11/5 assist the administrator and DON implementation of all corrective a ensure immediate and sustained compliance with standards of pra 	, and ptential to ce. For F584, 2 for full sident of their dance but is and sident achieve and t, afe, entified in hd F689, rrection. egan .24 to with ctions to		
	Review the center's least annually and r	a policies and procedures at make changes as necessary d compliance with current			regulations and implement the fol			

	RS FOR MEDICARE	AND HUMAN SERVICES				FORM OMB NO.	03/31/2025 APPROVED 0938-0391	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′			(X3) DATE SURVEY COMPLETED C		
		315524	B. WING	i			16/2024	
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL	BROOK REHABILITA	ATION AND HEALTHCARE CENT	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 835	Continued From pa	ge 159	F	835				
	regulations. Ensure visitors, and the ge established policies administrative auth accountability to oth necessary to perfor Ensure that all Cen visitors, etc., follow to include fire prote regulations, infection building and ground repair. Ensure that clean and safe mar convenience by ass equipment and sup perform such duties During the entrance 9:45 AM, the store () star months ago. At that facility had resident 1.) On 10/9/24 at 12 Resident #144's root NJ Ex Order 26.4(b)(1) observed lying in bow window open. At the interviewed the resi allowed to store in wait for hours for the to assist them. The did not take them of A review of Resident revealed that the resident	e that all employees, residents, neral public follow the center's and procedures. Delegate ority, responsibility, and her staff personnel as deemed in their assigned duties. ter personnel, residents, established safety regulations, ction/prevention, smoking on control, etc. Ensure that the ds are maintained in good the Center is maintained in a oner for resident comfort and suring that necessary plies are maintained to s/services. e conference on 10/8/24 at stated that she started at the ago and the US.FOIA(D)(0) ted at the facility NECOMPOSITION t time, the US.FOIA(D)(0) 2227 PM, the surveyor entered on and smelled a scent. The resident was ed with the fan on and the at time, the surveyor ident who stated they were not in their room, but they had to be staff to come into the room resident stated that the staff out to NECOMPOSATION		555	The Administrator Consultant s Assess the facility's compliance applicable state licensing stand identify areas of non-compliance Oversee the development, implementation, and evaluation corrective action plans Develop and implement compl management systems at the fa Collaborate with facility leaders ensure that operating procedur systems, and standards align w compliance requirements Ensure staff training needed tw with applicable licensing standa Take other actions as may be m to ensure the identification of co issues and implementation of the corrective measures Weekly reports will be provided Friday to NJDOH addressing co actions taken regarding: Identified areas of non-complia Corrective measures to address areas of non-compliance; and, Status of corrective measures implementation. The facility has retained the full on-site services of a Consultant of Nursing who has been appro Department of Health. The Consultant Director of Nurs be present in the facility for no 40 hours per week, with docum coverage of all shifts and week further notice from the Department contract with the consultant inc provisions for immediate correct with applicable state licensing s	e with all ards and e of iance cility hip to es, ith o comply ards; and, ecessary ompliance mely each orrective nce s identified -time, t Director wed by the sing shall ess than ented ends, until ient. The udes citive action		

Facility ID: NJ03015

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPI	E CONSTRUCTION	(X3) DAT	E SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	1 ° ′				PLETED
							0
		315524	B. WING				16/2024
NAME OF F	PROVIDER OR SUPPLIER			I	TREET ADDRESS, CITY, STATE, ZIP CO	DDE	
AUREL	BROOK REHABILIT	ATION AND HEALTHCARE CEN	ITER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 835	Continued From pa	age 160	F	835			
	was updated. During an interview at 1:30 PM, the user assessed as an NJ allowed to hold the asked did the resid	with the surveyor on 10/9/24 stated that the resident wa Ex Order 26.4(b)(1) and was ir Wexore 26.4(b)(1) and was ir Wexore 26.4(b)(1) and was	s n		The Consultant shall be resp ensuring that immediate corr is taken to verify that resider jeopardized, and applicable standards are met.	rective action nt safety is not	
	they had second in The surveyor condu- 10/16/24 at 8:48 AI Market the Resident #144 caring for the resid- resident had been staff "bend over ba- the facility had done	ucted a telephone interview o M, with the U.S. FOIA (b) (6) hat he had a problem with since they had been ent. The stated that the N Ex Order 26.4(b)(1) and that the ackward." The stated that e everything to keep the	n				
	 was going to "do be residents" and the of 2.) During the tour survey, it was determaintain the resider and living areas in a manner on all five resider to the survey. 	of the facility throughout the rmined that the facility failed t ents' environment, equipment a safe, sanitary, and homelike nursing units (East, West,	0				
	at 3:06 PM, the U.S stated in the presen	with the surveyor on 10/15/2)				

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 315524 B. WING 10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD			AND HUMAN SERVICES					FORM	03/31/2025 APPROVED 0938-0391
A. BOILDING C 315524 B. WING 10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF D	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPL	E CONSTRUCTION		(X3) DATE	E SURVEY
315524 B. WING 10/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	AND PLAN OF CO	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG .				
			315524	B. WING					
L 3/18 CHURCH ROAD	NAME OF PROVI	OVIDER OR SUPPLIER							
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER MOUNT LAUREL, NJ 08054	LAUREL BRC	ROOK REHABILITA	ATION AND HEALTHCARE CENTI						
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	¢	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD E	BE	(X5) COMPLETION DATE
F 835 Continued From page 161 F 835 survey team, the stated that the air conditioner (AC) vents were supposed to be wiped daily and deep cleaned weekly. The stated that she did not expect to see a thick coating of dust on the outside of the air-conditioning units. The stated that it could cause health issues in residents with respiratory problems. F 835 On 10/15/24 at 3:15 PM, the stated that the West Unit was the most difficult to clean. He stated ther was more movement and upkeep of the unit and that it was "harder to get clean with the clientele in that vicinity." During an interview with the surveyor on 10/15/24 at 4:14 PM, in the presence of the survey team, the stated that housekeeping and maintenance should ensure the AC units were cleaned and remained dust free weekly. 3.) On 10/08/24 from 9:30 AM to 10:45 AM, the surveyor, accompanied by the DECENDENT to prevent food borne illness. During an interview with the surveyor on 10/15/24 at 1:39 PM, the stated the nursing staff should be checking the unit pantries for expired food and monitoring the refrigerator temperatures daily. The further stated that food brought in by visitors should be labeled and dated with a use-by date since it would only be good for three days. The further stated that food brought in by visitors should not be dood for three days. The further stated that food brought in the stated that food brought in by visitors should not be storing the origin down in the state of and it was the since it would only be good for three days. The further stated that food brought in by visitors should nont be storing therefrigend temperatures the	surv con wip stat coa air it co resp On the stat the the the the the stat the the stat the the stat the the stat stat the stat the stat the stat the stat the stat stat stat stat stat stat stat sta	survey team, the sonditioner (AC) very viped daily and dee viped daily and dee stated that she did coating of dust on the could cause healthe espiratory problem on 10/15/24 at 3:19 he West Unit was so that does there was make unit and that it was stated and remain there was make unit 1:59 PM, the stated there was make unit 1:59 PM, the stated there was make unit on a safe or event food borne. Ouring an interview was 1:59 PM, the stated there was make unit on a safe or event food borne of the stated there was make unit on a safe or event food borne. Ouring an interview was should be checking on and monitoring the stated there was make unit of the stated there was make unit on the stated there was make unit to be the stated there was make unit to be the state there was make unit to be the state there was make unit to be there was make unit	stated that the air ents were supposed to be ep cleaned weekly. The state not expect to see a thick the outside of the its. The stated that the issues in residents with ns. 5 PM, the stated that the most difficult to clean. He nore movement and upkeep of was "harder to get clean with t vicinity." with the surveyor on 10/15/24 presence of the survey team, nat housekeeping and Id ensure the AC units were ined dust free weekly. om 9:30 AM to 10:45 AM, the anied by the U.S. FOIA (b) (6) red the kitchen and it was e facility failed to handle ous foods and maintain e and consistent manner to e illness. with the surveyor on 10/15/24 the stated the nursing staff g the unit pantries for expired ng the refrigerator temperatures ther stated that food brought in be labeled and dated with a it would only be good for three lded that staff members should	F 83	35				

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES				1	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '		E CONSTRUCTION		E SURVEY PLETED
		315524	B. WING				C 16/2024
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		10/2024
		TION AND HEALTHCARE CENTE	-	37	718 CHURCH ROAD		
				M	IOUNT LAUREL, NJ 08054		
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	,	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	•	CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
E 925	Continued From no		– •				
F 835	-	-	F 83	35			
	reingerators design	ated for resident food.					
		10:08 AM, the surveyor					
	Resident #97.	onic medical record (EMR) for					
		SARR level I Screening Tool					
		igned by the facility's US FOR (b)					
	Section NJ Ex Orde	ated the following: ar 26.4(b)(1)					
		Screen NJ Ex Order 26.4(b)(1)					
		screening, which required a					
	level II PASARR to	be completed.					
	Further review of th	e EMR revealed there was no					
	evidence of a level	II PASARR was completed.					
	During an interview	with the surveyor on 10/15/24					
		stated in the presence of					
	the U.S. FOIA (b) (6	6)), ^{U.S. FOIA (b) (8)}					
), the					
	U.S. FOIA (b) (6)),),), n that the expectation was that					
		R would be completed prior to					
	admitting the reside	ent. The us FOA(0) acknowledged					
		ARR should have been					
	completed.						
		ident #73, #102 and #198					
		prehensive care plan (ICCP)					
	revealed conflicting	interventions related to					
		nt #198's ICCP included a					
	focus, created						
		e all <mark>NJ Ex Order 26.4(b)(1)</mark> in my					

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						F	ORM	03/31/2025 APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPL	E CONSTRUCTION			0938-0391
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		ſ		PLETED
		315524	B. WING _			C 10/16/20		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE		(X5) COMPLETION DATE
F 835	room," and that, "th NJ Ex Order 26.4(b)(1)." A review of Resider dated of VECOME 26.4(b)(1)." understand that for my NJ Ex Order 26.4(b)(1)." understand that for my NJ Ex Order 26.4(b)(1) that the facility will s for safety reason, I (initia NJ Ex Order 26.4(b)(1) (initia A review of Resider focus, revised VECOME included two conflic to NJ Ex Order 26.4(b)(1) the facility will safety " During an interview at 4:20 PM, in the p the VECOME stated tha auto populated by the Safety Evaluation a interventions should next day by nursing 6.) A review of 5 of #40, #109, #167, ar medications reveale addressed: recomm reduction (GDR) of (NJ Ex Order 26.4(b)(1) med (PRN) N Ex Order 26.4(b)(1)	e facility will safely secure all " " " " " " " " " " " " " " " " " "	F 83	35	DEFICIENCY)			
	with a 14-day durat	medications were prescribed ion and re-evaluated for adequately monitor target						

Facility ID: NJ03015

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		AND HUMAN SERVICES			FORM	03/31/2025 APPROVED 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	IPLE CONSTRUCTION	` ́сом	E SURVEY PLETED	
		315524	B. WING			C 16/2024	
			_	STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD			
LAUREL		TION AND HEALTHCARE CENTE		MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 835	Continued From par medications. A review of Resider , dated reported they had b them NJ Ex Order 26.4(b)(1) stop NJ Ex Order 2 Further review of the recommendations of Netcorrection and NEX A review of Resider Medication Ac revealed there were monitor target NEX medication use price A review of Resider Medication use price A review of Resider medication use price A review of Resider NEX Order 20.4(0)(1) and NUE Treatment Administ include any PO for related to NEX ORDER 10 of	ge 164 se of WEXORDEr 26.4(b)(1) at #17's NJ Ex Order 26.4(b)(1) WEXORDER 26.4(b)(1) WEXORDER 26.4(b)(1) because it gave and that they requested to 6.4(b)(1) because it gave and that they requested to 6.4(b)(1) and the conservation and that they requested to 6.4(b)(1) and the conservation and that they requested to 6.4(b)(1) and the conservation and the conservation and the conservation and the conservation and that they requested to and the conservation and t	F 83	DEFICIENCY)			
	Physician Order Su reflected that the re NEX Order 26.4(b)(1) medic A physician's order NJ Ex Order 26.4(b)	mmary Report (OSR) sident was on the following cations: (PO), dated ^{NECORDITION} , for ()(1) at by mouth every 12 hours as order 26.4(b)(1)					
	A review of Resider NJEXOrder204(b)(1) did not include any related to NJEXORE 204(C) N	x Order 26.4(b)(1) MARs and TARs					

Facility ID: NJ03015

		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPL	E CONSTRUCTION		0938-0391
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	1 ° '			СОМ	PLETED
		315524	B. WING				C 16/2024
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	NTER 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 835	Continued From par medications. A review of Resider 10/16/24, included to A PO dated Control of administer one table for Control of Resider did not include any monitoring of side e medications prior to A review of Resider resident had an ord ; give bedtime for Control There was no evide behavior was being During an interview at 3:45 PM, in the p U.S. FOIA (b) (6) an stated that a PO for stop date on the ord During an interview at 3:57 PM, in the p the Control of Stated the set to create physic	ge 165 at #109's OSR dated as of the following PO: , for NJ Ex Order 26.4(b)(1); et by mouth two times a day at 109's NJ Ex Order 26.4(b)(1) MAR NECORE 26.4(b)(1) MAR NECORE 26.4(b)(1) MAR NECORE 26.4(b)(1) o surveyor inquiry. at #167's PO revealed that the ler for NJ Ex Order 26.4(b)(1) o ne tablet by mouth at 26.4(b)(1). ence that the resident's monitored. with the surveyor on 10/15/24 oresence of the U.S. FOIA (b) (6) ad the survey team, the U.S. FOIA (b) (6) ad the surveyor on 10/15/24 with the surveyor on 10/15/24 oresence of the survey team, facility utilized a batch order	F 8	35			
	every shift. During an interview at 4:18 PM, in the p	with the surveyor on 10/15/24 resence of the survey team, t					

		AND HUMAN SERVICES			FORM): 03/31/202 //APPROVE). 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION		TE SURVEY MPLETED	
		315524	B. WING		C 10/16/2024		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
LAUREL	BROOK REHABILIT	TION AND HEALTHCARE CENT	ER I	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 880	the provider. The provider should doo medical record whe reviewed. On 10/16/24 at 10:2 acknowledged the	26 AM, the Material and the brought to presence of the Material and the Material an	F 83			11/21/24	
	infection prevention designed to provide comfortable environ development and tr diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the foll §483.80(a)(1) A sys reporting, investiga and communicable staff, volunteers, via providing services of arrangement based	tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ransmission of communicable tions. In prevention and control atablish an infection prevention n (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ng to §483.71 and following					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		315524	B. WING_				C 16/2024
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) Completion Date
F 880		-	F 88	80			
	procedures for the p but are not limited to (i) A system of surve possible communic infections before the persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tra- to be followed to pro- (iv)When and how i resident; including to (A) The type and du depending upon the involved, and (B) A requirement the least restrictive pos- circumstances. (v) The circumstance must prohibit emplo- disease or infected contact with resider contact with resider contact will transmit (vi)The hand hygier by staff involved in of §483.80(a)(4) A sys- identified under the corrective actions ta §483.80(e) Linens. Personnel must har	eillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a but not limited to: iration of the isolation, e infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct the disease; and he procedures to be followed direct resident contact. them for recording incidents facility's IPCP and the					

Facility ID: NJ03015

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315524	B. WING	;			_ 16/2024
NAME OF F	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CO		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENT	ER	I .	718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) Completion Date
F 880	 80 Continued From page 168 §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: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to A.) perform hand hygiene before preparing and administering medications. B.) failed to maintain a non-touch technique when returning excess medication to the original bottle. and C. failed to disinfect the blood pressure equipment after each use. This breach in infection control practice occurred during 2 of 4 medication administration observation. This deficient practice was evidenced by the following: 		F	880	 Resident #92 was review licensed nurse with NJ Ex Order related to cited event. Resident # 16 was reviewed I nurse with NJ Ex Order 26.4(b)(1) cited event. The Infection Preventionist re LPN #1 and LPN #7 on the fai infection prevention policy to not limited to performing hand before preparing and adminis medications, maintaining a not technique when returning exc medication to the original bott disinfecting blood pressure exa after each use. 	26.4(5)(1) by licensed related to -educated acility include but d hygiene tering bon-touch tess te, and quipment	
	Medication Adminis observed Licensed prepare and admini medication. He/She prior to preparing the after administration 2.) During the same Resident #92 had a give hours. LPN #1 error the bottle cap instea returned the excess she touched the resident the bottle along with the	e medication observation, in order for WEX order 264(b)(1) e two tablet by mouth every 12 neously poured 3 tablets into ad of 2 tablets. As LPN #1 s tablet to the original bottle, sident's 2 tablets with bare em from falling back into the			 Current residents have the be affected by this deficient provide audit was completed during in pass to determine is nurses of following proper infection commedication administration pratification administration pratification administration pratification prevention Preventioni re-educated licensed nurses infection prevention policy to not limited to performing hand before preparing and administ medications, maintaining a not technique when returning excommedication to the original both disinfecting blood pressure exafter each use Staff education included those 	ractice. An nedication vere trol and actices. No st on the facility include but d hygiene tering on-touch sess tle, and quipment	

Facility ID: NJ03015

		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		315524	B. WING				16/2024
	PROVIDER OR SUPPLIER	ATION AND HEALTHCARE CENTE	ER	37	TREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) Completion Date
F 880	observation, LPN#7 observation, LPN#7). He/3 after 1 On 10/10/24 at 10:3 with the surveyor, v hygiene be perform entering and exiting was also asked wh be cleaned? SI cleaned immediate resident." On 10/11/24 at 11:5 the surveyor, the U stated, hand should medication pass an resident, by using a washing with soap During further intern that pills should new hands. When asked what i Netocorres, the state every use, take the sanitize them befor A review of the faci "Hand Washing/Ha Practices to Promo personnel are trainer the importance of h the transmission of	7 took Resident #16's Metoder She did not disinfect the Metoder taking the resident's Metoder 55 AM, during an interview when asked when should hand hed, LPN/UM#1 stated before g a resident's room. LPN/#1 en should a MEXOrder 264(b)(1) he/He stated, "it should be ly after use and after every 54 AM, during an interview with S. FOIA (b) (6) d be performed prior to hd after and in between each alcohol based hand sanitizer or and water. view with the Metoder She/he stated ver be touched with bare is the process for cleaning the ed, it should be cleaned after m and wipe it down and re using it for the next person. lity policy revised in 10/2023, and Hygiene Administrative the Hand Hygiene 1. All ed and regularly in-serviced on hand hygiene and preventing i healthcare-associated ans for Hand Hygiene 1 C. lood, body fluids or	F8	80	the 2567 4. The Infection Preventionist /designee will complete 3 rounds du medication pass to determine if nur were following proper infection com- medication administration practices Variances will be addressed. These will be conducted weekly x 4 weeks monthly x 2 months. The findings o audits will be submitted by the Infe Preventionist to the QAPI Commit review and recommendation month- months or ongoing until compliance sustained.	rses trol and s. e audits s, then f the ction tee for ily for 3	

		AND HUMAN SERVICES			FOF	O: 03/31/2025 MAPPROVED O: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) D	ATE SURVEY OMPLETED
		315524	B. WING		1	C 0/16/2024
	PROVIDER OR SUPPLIER	TION AND HEALTHCARE CEN	TER	STREET ADDRESS, CITY, STATE, 3718 CHURCH ROAD MOUNT LAUREL, NJ 0805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	F CORRECTION CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 170	F 880	ט		
	NJAC 8:39-19.4(a)					
FORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID: UBX	H11 F	acility ID: NJ03015	If continuation sheet	Page 171 of 171

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY
		ibertin lo, thorthombert.	A. BUILDING	·	
		03015	B. WING	1	C 0/16/2024
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
AUREL		TION AND HEAL'	URCH ROAD LAUREL, NJ		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
H 000	Initials Comments		H 000		
	8 Chapter 43E- Ge	compliance with N.J.A.C. Title neral Licensure Procedures licable To All Licensed	2		
H5790	8:43E-13.4(d) UNI FORM:MANDATOR	/ERSAL TRANSFER RY USE OF FORM	H5790		11/21/24
	retain a completed Form sent with a pa	re facility or program shall copy of the Universal Transfer atient when a patient is of the patient's medical			
	by: Based on interview other pertinent facil determined that the completed copy of Transfer Form (NJU record. This deficie one (1) of two (2) re hospitalizations (Re evidenced by the fo	rsey Hospital Association		 Resident #137 NJ Ex Order 26.4(b)(1) in the facility. Current residents that are transferre to the hospital have the potential to be affected by the cited occurrence to maintain a completed copy of the New Jersey Universal Transfer Form (NJUTF as part of the medical record. An audit was completed of all residents who were transferred to hospital form 10/9/24 to present to validate New Jersey Universal 	·)
	used by all licensed	ransfer Form (UTF) must be I healthcare facilities and atient is transferred from one		Transfer Form was completed. No furth variances were noted. 3. DON re-educated licensed nursing staff on the need to complete and	

Electronically Signed

11/10/24

6899

If continuation sheet 1 of 18

STATEMEN	sey Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		03015	B. WING		C 10/16/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
AUREL	BROOK REHABILITA	ATION AND HEAL	URCH ROAD LAUREL, NJ			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) Complet Date
H5790	Continued From pa	ge 1	H5790			
	A review of the Admission Record face sheet (an admission summary) reflected that the resident had diagnosis that included, ^{NJ Ex Order 26.4(b)(1)} , ^{N Ex Order 26.4(b)(1)} , and NJ Ex Order 26.4(b)(1)			maintain a completed copy Jersey Universal Transfer F as part of the medical record 4. These audits will be co x 4 weeks, then monthly x 2 findings of the audits will be the Director of Nursing to th Committee for review and	Form (NJUTF) rd. nducted weekly 2 months. The e submitted by ne QAPI	
	Nurse's Note (NN) On Metoderstatiat 8:26 (NP) was in to assessed the resident to On Metoderstatiat 9:10	AM, transportation to the		recommendation monthly for ongoing until compliance is		
	On ^{WEX Order 25.4(0)} was sched On ^{WEX Order 25.4(0)} at 6:12 to the ^{WEX Order 25.4(0)} for <mark>NJ</mark>	AM, the resident was admitted	ı			
		PN did not indicate the the facility or was transferred				
	in the EMR was inc resident's date of tr 12:10 PM. It further required information completed) were bl status, #8 reason fo diagnosis, #10 rest #12 isolation/precar conditions, #16 dief #18, personal items attached document mental status, #22 Screening and Res	AM, a review of the NJUTF complete and indicated the cansfer was on the value of the following in (Items 1-29 must be ank: #1 transfer to, #6 code or transfer, #9 primary raints, #11 respiratory needs, utions, #14 sensory, #15 skin t, #17 IV [intravenous] access, is sent with resident, #19 is, #20 at risk alerts, #21 PASRR (Preadmission ident Review- is a federal o ensure that individuals are				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	E SURVEY PLETED
		03015	B. WING		10/	16/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
	BROOK REHABILITA	ATION AND HEAL'	URCH ROAD			
		MOUNT	LAUREL, NJ	08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CO(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTIONREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE DEFICIENCY)				(X5) COMPLET DATE
H5790	Continued From pa	ige 2	H5790			
	bladder, #27 sendir	unction, #25 bowel, #26 ng facility contact, #28 form cable), and #29 form				
	at 9:45 AM, the Lice Manager (LPN/UM she has worked at i months. LPN/UM # the Universal Trans resident was transfit the SBAR [Situation Recommendation] record (EMR). She out the resident's p face sheet, orders f and the Universal T stated generally the the UTF for it to go explained it was fille printed. When aske LPN/UM stated, "I c send it to the Nerocce Resident #137 was Nerocce due to an N and the admitting d NJ Ex Order 264(D)(1). She that the SBAR was wrote everything on resident to be transf					
	at 10:11 AM, the Lie #6) stated when a r Universal Transfer medications, the re	with the surveyor on 10/16/24 censed Practical Nurse (LPN resident was transferred the form, a list of their cent labs, orders, and recent n the doctor if they were				

STATEMEN	sey Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION	СОМ	E SURVEY PLETED
		03015	B. WING		10/16/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
LAUREL	BROOK REHABILITA	ATION AND HEAL	URCH ROAD LAUREL, NJ(08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) Complet Date
H5790	Continued From pa	ige 3	H5790			
	them out. LPN #6 s	ew why we were transferring stated the resident was sent ad <mark>NJ Ex Order 26.4(b)(1)</mark> .				
	at 10:30 AM, the completed until ^{Nexo} the resident was se their ^{Nexoestad} (0) was had a NJ Ex Order) stated the NJUTF was not certost. She stated the reason ent to the hospital was because NEXCOMPTOSTAND and the resident				
	completely filled ou the NJUTF should). ed the NJUTF was not done or UTF dated Westerstor was not t. The LNHA acknowledged be completed the day the erred, and it should be filled				
	Transfer Form" und will ensure a compl Universal Transfer resident at the time another licensed he	lity's "New Jersey Universal lated, included "2. The facility letedcopy of the New Jersey Form is sent with each of the patient's transfer to ealthcare facility or program. 2. New Jersey Universal Transfer eted"				
S 000	Initial Comments		S 000			
	Standards in the Ne Code, Chapter 8:39 Long Term Care Fa submit a plan of co completion date, fo	compliance with the ew Jersey Administrative 9, Standards for Licensure of acilities. The facility must rrection, including a r each deficiency and ensure lemented. Failure to correct				

	sey Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY IPLETED	
		03015	B. WING	10	C 10/16/2024	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AUREL	BROOK REHABILITA	ATION AND HEAL'	IRCH ROAD AUREL, NJ			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
S 000	Continued From pa	ige 4	S 000			
	accordance with the Administrative Code	esult in enforcement action in e Provisions of the New Jersey e, Title 8, Chapter 43E, ensure Regulations.				
S 560	8:39-5.1(a) Mandat	ory Access to Care	S 560		11/21/24	
		mply with applicable Federal, /s, rules, and regulations.				
	by: Based on observati pertinent facility doo determined the faci required minimum of ratios as mandated This deficient pract following: Reference: NJ Stat	NT is not met as evidenced ion, interview, and review of cumentation, it was ility failed to maintain the direct care staff-to-resident I by the State of New Jersey. ice was evidenced by the re requirement, CHAPTER ning staffing requirements for		 An ongoing staffing analysis is reviewed by shift to determine the amoun of direct care staff and licensed nursing staff required by regulatory requirements to meet the care needs of the residents based on the daily census and is used to ensure additional staff are scheduled to cover call outs. Vacancy and retention rates are analyzed weekly by the DON, Staffing 	t	
	nursing homes and Revised Statutes. Be It Enacted by Assembly of the Sta	the Senate and General the Senate and General ate of New Jersey: C.30:13-18 equirements for nursing homes		 Coordinator, and Administrator and communicated to the corporate team to ensure adequate staffing to identify additional hiring to ensure care needs and regulatory requirements are met. A \$2K bonus was implemented to convert per diem nursing staff to fulltime positions. 	1	
	requirements as ma every nursing home	nding any other staffing ay be established by law, e as defined in section 2 of .30:13-2) or licensed pursuant		 Forfeit of Employee Benefits "No frills rates were increased from \$3 to \$4 per hour. Perfect attendance bonuses were 	77	

STATEMEN	Sey Department of H T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		03015	B. WING		C 10/16	/2024
	PROVIDER OR SUPPLIER	TION AND HEAL 3718 CHU	RCH ROAD			
	I		AUREL, NJ			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) Complet Date
S 560	Continued From pa	ge 5	S 560			
S 560	to P.L.1971, c.136 (maintain the followi -to-resident ratios: (1) one certified residents for the da (2) one direct of residents for the ev fewer than half of a certified nurse aide shall be signed in to aide and shall perfor and (3) one direct of residents for the nig direct care staff me certified nurse aide aide duties b. Upon any expan the nursing home, t exempt from any in ratios for a period of the date of the expan c. (1) The computar staffing ratios shall place. (2) If the applic subsection a. of this a whole number of	(C.26:2H-1 et seq.) shall ng minimum direct care staff d nurse aide to every eight y shift; eare staff member to every 10 ening shift, provided that no II staff members shall be s, and each staff member o work as a certified nurse orm certified nurse aide duties, eare staff member to every 14 ght shift, provided that each mber shall sign in to work as a and perform certified nurse hsion of resident census by the nursing home shall be crease in direct care staffing of nine consecutive shifts from ansion of the resident census. tion of minimum direct care be carried to the hundredth eation of the ratios listed in s section results in other than direct care staff, including	S 560	 implemented. Perfect attendance and vacan pickup raffles were implemented a include special raffles for upcomin holiday coverage to minimize callo Exit interviews are conducted determine reasons for nursing stat separation with resignations. Another CNA job fair is schedu 11/12/24. Daily recruitment and onboard are held with the facility managem regional support teams. Corporate reviews are conduct of prior day staffing of actual to scl CNA's to determine if the ratio of a resident is met with actions taken on reviews. OnShift software is used to en daily staffing complies with regulat requirements and resident acuities used off shifts by nursing supervis cover call outs. The staffing schedule was reviby the DON, DON consultant, Administrator, and the staffing coot to identify by shift the required nundirect care and licensed nursing stabased on current and projected ce Staffing schedules include sch additional on call direct care staff tunexpected call outs. Innovative scheduling is being ensure adequate licensed nursing 	and g buts. to ff uled for ling calls ent and ted daily heduled aide to based sure fory s and is ors to iewed ordinator nber of taff ensus. heduling to cover used to staff	
	a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.			meet the regulatory requirements resident care needs based on acu This includes per diem and RN ad nurses and part time or per diem L cover callouts and vacations of reg scheduled staff.	and ities. mission _PN's to	

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New Jer	sey Department of I	lealth	_			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPLE	
	of connection	IDENTIFICATION NOMBER.	A. BUILDING	а <u></u>		
			5.000		С	
		03015	B. WING		10/16	/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
		3718 CH)		
LAUREL	BROOK REHABILIT	ATION AND HEAL MOUNT	LAUREL, NJ	08054		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PRÉFIX	-		PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
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0.500	0 (; 15	2	0.500			
\$ 560	Continued From pa	age 6	S 560			
	(3) All compute	ations shall be based on the		The facility has agreements wi		
	midnight census fo	r the day in which the shift		and LPN programs/schools to utiliz		
	begins.			facility as a clinical site for their stu	idents.	
				 A QAPI root cause analysis was 	as	
		section shall be construed to		conducted and a performance		
		n staffing requirements for		improvement project (PIP) was		
		may be required by the		implemented that includes direct c		
		lealth for staff other than direct	:	licensed nurses from all shifts to id		
		g certified nurse aides, or to		internal and external barriers to att		
		f a nursing home to increase		new staff. The PIP members are r		
		ny time, beyond the		recommendations to management	based	
	established minimu	um		on their discussions.		
	A			Focus groups have been cond		
		ersey Department of Health		on all three shifts and weekends to		
		ssessment and Survey		issues or concerns direct care and		
		affing Report" for the 2 weeks		licensed nursing staff may have an	а зеек	
		survey from 09/22/2024 to		input.	0000	
		cility was deficient in CNA ts on 14 of 14 day shifts as		 Assignments were reviewed to residents with high acuities are equilated and acuities are		
	follows:	is on 14 of 14 day shifts as		distributed on direct care staff	ually	
	101101103.			assignments.		
	-09/22/24 had 14 (NAs for 199 residents on the		Performance evaluations are		
	day shift, required			completed and targeted education		
		CNAs for 197 residents on the		provided to staff to ensure they fee		
	day shift, required			competent in their role to enhance		
		CNAs for 197 residents on the		satisfaction.		
	day shift, required			 Job applications are readily av 	ailable	
		CNAs for 197 residents on the		at the reception desk to ensure ind		
	day shift, required	at least 25 CNAs.		looking for a job can be provided w		
		NAs for 194 residents on the		application immediately and an inte	erview	
	day shift, required	at least 24 CNAs.		can be coordinated that same day	to	
		NAs for 194 residents on the		expedite hiring.		
	day shift, required			 Signs are posted in and outsid 		
		CNAs for 194 residents on the		facility and in local community setti	ings to	
	day shift, required	at least 24 CNAs.		attract new hires.		
				 Phones calls have been made 		
		CNAs for 194 residents on the		employees who resigned in good s		
	day shift, required			to inform them of current rates and	k	
		CNAs for 199 residents on the		interest in rehiring.		
	day shift, required	at least 25 CNAs.				

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	sey Department of H					
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SU COMPLE	
		03015	B. WING		C 10/16/	2024
	PROVIDER OR SUPPLIER	STREET AD		STATE, ZIP CODE		
	KONDER OR SOFFEIER					
LAUREL	BROOK REHABILITA	ATION AND HEAL	AUREL, NJ			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)		DATE
S 560	Continued From pa	ige 7	S 560			
	-10/01/24 had 18 C	NAs for 199 residents on the		2 All residents have the potentia	l to be	
	day shift, required a			affected by this practice.		
	-10/02/24 had 16 C	NAs for 199 residents on the				
	day shift, required a			1. The action plan for back up sta		
		NAs for 199 residents on the		ensure meeting staffing to resident		
	day shift, required a	NAs for 207 residents on the		was reviewed and updated as follo o An on call pool of nursing staff		
	day shift, required a			developed that includes CNAs, LP		
		NAs for 207 residents on the		RNs as needed with sister facilities		
	day shift, required a			area. The pool expands the current		
				call staff from within the facility. A	dditional	
		with the surveyor on 10/11/24		incentives are provided to on call s		
		ffing Coordinator (SC) was		Transportation to the facility via fac	cility	
		the required minimum direct		transport and/or Uber or other	rod to	
		nt ratios as mandated by the y. The SC further stated that		transportation methods will be offe staff as part ot he pool.	ared to	
		es with low weekend staffing		o Transportation pools are also		
	rates at the facility.	-		available to staff who may live in si	imilar	
				geographic areas to attract and ref		
		with the surveyor on 10/11/24		employees.		
		ector of Nursing (DON) who		o Agreements are in place with		
		ribe the required minimum		facilities to utilize extra staff as nee		
		resident ratios as mandated by ersey. The DON stated, "Let		ensuring adequate staff and provid employees throughout the organize		
		s, I do not know them by		with access to additional hours of		
		ated that he felt that the SC		o The On Shift software utilized		
	should be able to s	peak to the state mandated		facility enables the off shift supervi	-	
		rther stated that there had		and nurse managers to quickly cor	ntact	
	been shortfalls on v	weekend staffing.		staff who are interested in picking	up	
	On 10/15/04 -+ 4-5	DDM the europeinteen		additional shifts.	# ~~	
	informed the Licens	0 PM, the survey team		 The corporate Cultural commit plans events to recognize all staff 		
		A), the Vice President of		additional incentives for those who		
		egional Director of Clinical		above and beyond caring for reside		
		he Regional Director of		The cultural committee will review		
	Operations (RDO),	and the Director of Nursing		recommendations from the Staffing	g	
		when the minimum direct care		Performance Improvement Project		
	staff to resident rati	o was not met.		members and nursing staff meetin		
		litula Chaffing Cufficient and		implementation and will review and		
	A review of the faci	lity's Staffing, Sufficient and		address both internal and external	parriers	

	sey Department of H	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		:	COMPL	
		03015	B. WING	C 10/16/2024		
AME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	BROOK REHABILITA	STION AND HEAL. 3718 CHU	JRCH ROAD	•		
AUREL		MOUNT L	AUREL, NJ	08054		
(X4) <mark>I</mark> D PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	TION ULD BE ROPRIATE	(X5) Complet Date	
S 560	Continued From pa	ige 8	S 560			
	Competent Nursing included, "7. Factor appropriate staffing 8. minimum staffing	g" policy revised August 2022, rs considered in determining ratio and skillsand acuity; g requirements imposed by to when determining staff		 identified by the PIP. The facility will secure contrasupplemental staffing that will be needed. Administration has formed a committee and has conducted sanalyses and implemented creas strategies for attracting new emminimize the use of agency personal the goal of zero use of supplemented to attract greatin current staff have been reand modified to attract more new. Referral bonuses for current employees supports filling vacar positions as well as retaining cut. An employee recognition co comprised of front line workers wimplemented to plan events to it morale of staff, recognize the exservices provided by staff, and r work environment enjoyable. Quarterly employee apprecies events are planned by the employee recognition committee to improvements in the environ working conditions have helped new staff. The facility utilizes all types and digital media as well as hear to identify and hire new staff. The facility management tea working with the union to promo cooperation, to enhance hiring, minimize call outs. 	e used as a staffing alary tive ployees to connel with ental rams ct and to viewed w hires. t trrent staff. mmittee was mprove the cemplary nake the ation byee re yees. ment and attract of social dhunters am is te	
New Jer	sey Department of H	lealth				
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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X	(3) DATE (COMPL	
		03015	B. WING		C 10/16/2024	
	PROVIDER OR SUPPLIER	ATION AND HEAL 3718 CHL	DRESS, CITY, S JRCH ROAD AUREL, NJ			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) Complete Date
S 560	Continued From pa	age 9	S 560	 facility core team and management company and additional incentives a provided for working an extra shift if needed. The success of bonuses ar incentives is analyzed by the facility Administrator and Director of Nursing make recommendations to the QAP compliance committee at weekly me regarding what incentives or bonuse attracting new hires. Staffing is discussed at daily mo operations meetings and recommendations solicited from the management team about ways to att new hires to fill vacant positions. Staffing levels of direct care staff recruitment efforts are discussed da nursing management and the administrator, are reported monthly to corporate clinical team, and are revie at the quarterly QAPI committee meet. Vacancy rates are reviewed weet the Director of Nursing and discusse the Administrator. The effectiveness strategies to attract and retain staff a discussed and strategies modified at needed. Findings are also discusse monthly with the corporate team that provides direct assistance with recruitee forts. 	nd g who I eetings es are orning tract ff and ily by to the ewed etings. ekly by ed with s of are s d	
S1680	(b) The facility shal registered professionurses, and nurse of nursing are not i except for the direct) Mandatory Nurse Staffing I provide nursing services by onal nurses, licensed practical aides (the hours of the director ncluded in this computation, ct care hours of the director of where the director of nursing	S1680			11/21/24

STATE FORM

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If continuation sheet 10 of 18

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ DPLAN OF CORRECTION IDENTIFICATION NUMB			LE CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		03015	B. WING		10/16/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE	
AUREL	BROOK REHABILITA	ATION AND HEAL	URCH ROAD LAUREL, NJ		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D 175
S1680	S1680 Continued From page 11		S1680		
	This REQUIREME	NT is not met as evidenced			
	Based on review of the weeks prior to s	the Nurse Staffing Reports for survey from 9/22/2024 to		S1680 Mandatory Nurse Staffing	in
		etermined that the facility least minimum staffing levels		 An ongoing staffing analysis reviewed by shift to determine the ar 	
	for 2 of 14 days. Th actual staffing hour	e required staffing hours and s are as follows:		of licensed nursing staff required by regulatory requirements to meet the	
	For the week of 9/2	2/2024		needs of the residents based on the census and is used to ensure addition	
	Required Total Staf	fing Hours: 555.75		staff are scheduled to cover call outs	
		actual staffing hours, for a		 Vacancy and retention rates are analyzed weekly by the DON, Staffin 	
	difference of -19.75	b hours.		Coordinator, and Administrator and communicated to the corporate team onsure adequate staffing to identify	n to
	For the week of 9/2	9/2024		ensure adequate staffing to identify additional hiring to ensure care need	ls and
	Required Total Staf	fing Hours: 575.75		 regulatory requirements are met. A \$2K bonus was implemented t 	
	-10/5/24 had 568 a	ctual staffing hours, for a		 A \$2K bonus was implemented to convert per diem nursing staff to fullt 	
	difference of -7.75			positions.	

	sey Department of H					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		03015	B. WING		C 10/1	; 6/2024
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
		3718 CH	URCH ROAD			
AUREL	BROOK REHABILITA	MOUNT I	LAUREL, NJ	08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) Complet Date
S1680	Continued From pa	age 12	S1680			
	A review of the faci Competent Nursing included, "7. Factor appropriate staffing 8. minimum staffing	lity's Staffiing, Sufficient and g" policy revised August 2022, rs considered in determining g ratio and skillsand acuity; g requirements imposed by to when determining staff		 rates were increased from \$3 to hour. Perfect attendance bonuses implemented. Perfect attendance and vac pickup raffles were implemented include special raffles for upcomholiday coverage to minimize cate. Exit interviews are conducted determine reasons for nursing separation with resignations. Daily recruitment and onboa are held with the facility manage regional support teams. OnShift software is used to daily staffing complies with regurequirements and resident acuit used off shifts by nursing super cover call outs. The staffing schedule was result of the poly. DON consultant, Administrator, and the staffing of to identify by shift the required regurement and projected Staffing schedules include sadditional on call direct care statunexpected call outs. Innovative scheduling is beit ensure adequate licensed nursing based on a This includes per diem and RN nurses and part time or per dier cover callouts and vacations of schedule staff. The facility has agreements and LPN programs/schools to uf facility as a clinical site for their A QAPI root cause analysis 	ant shift d and hing illouts. ed to taff arding calls ement and ensure latory ies and is visors to eviewed oordinator umber of staff census. scheduling ff to cover ing used to ng staff ts and cuities. admission n LPN's to regularly with CNA tilize the students.	

STATEME	Jersey Department of Health MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:		
		03015	B. WING		C 10/16/2024	
	PROVIDER OR SUPPLIER . BROOK REHABILIT/	ATION AND HEAL	DDRESS, CITY, IURCH ROAD LAUREL, NJ			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) Completi Date
S1680	Continued From pa	age 13	S1680	 conducted and a performance improvement project (PIP) was implemented that includes direct licensed nurses from all shifts to internal and external barriers to new staff. The PIP members arrecommendations to manageme on their discussions. Focus groups have been coordinated nursing staff may have been coordinated nursing staff may have input. Assignments were reviewed residents with high acuities are distributed. Performance evaluations arr completed and targeted education provided to staff to ensure they competent in their role to enhant satisfaction. Job applications are readily at the reception desk to ensure looking for a job can be provide application immediately and an can be coordinated that same dexpedite hiring. Signs are posted in and out facility and in local community s attract new hires. Phones calls have been matemployees who resigned in goot to inform them of current rates a interest in rehiring. All residents have the potent affected by this practice. The action plan for back up 	o identify attract re making ent based onducted s to identify and seek d to assure equally re on feel ce job available individuals d with an interview ay to side the ettings to de to prior d standing and tial to be	

	W Jersey Department of Health ITEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	LE CONSTRUCTION ((X3) DATE SURVEY		
and plan	OF CORRECTION	IDENTIFICATION NUMBER:		·	COMPLETED		
		03015	B. WING		C 10/16/2024		
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS CITY	STATE, ZIP CODE			
		3718 CH	URCH ROAD				
LAUREL	BROOK REHABILIT	ATION AND HEAL MOUNT	LAUREL, NJ	08054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE		
S1680	Continued From pa	age 14	S1680				
				 ensure meeting staffing to resident if was reviewed and updated as follow o An on call pool of nursing staff if developed that includes CNAs, LPN RNs as needed with sister facilities area. The pool expands the current call staff from within the facility. Additionentives are provided to on call staff transportation to the facility via facilit transport and/or Uber or other transportation methods will be offered staff as part of he pool. o Transportation pools are also available to staff who may live in sin geographic areas to attract and retain employees. o Agreements are in place with si facilities to utilize extra staff as needed with access to additional hours of woo The On Shift software utilized by facility enables the off shift supervisiand nurse managers to quickly contistaff who are interested in picking upditional shifts. o The corporate Cultural committed plans events to recognize all staff with additional incentives for those who gabove and beyond caring for resided the cultural committee will review recommendations from the Staffing Performance Improvement Project of members and nursing staff meeting implementation and will review and address both internal and external to identified by the PIP. o The facility will secure contracts supplemental staffing that will be usineeded. 	v: was Is, and in the t on ditional aff. lity ed to nilar ain ster ded, ng tion ork. y the ors tact p ee ith go nts. (PIP) Is for parriers a for		

STATEME	Jersey Department of Health IMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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S1680	Continued From p	age 15	S1680	 Administration has formed committee and has conducted analyses and implemented creastrategies for attracting new emminimize the use of agency per the goal of zero use of supplem staffing. Bonuses and incentive propreviously implemented to attract more near and modified to attract more near and modified to attract more near modified to attract more near and modified to attract more near and modified to attract more near and modified to attract more near suppose supports filling vacations as well as retaining comprised of front line workers implemented to plan events to morale of staff, recognize the eservices provided by staff, and work environment enjoyable. Quarterly employee apprece events are planned by the emp recognition committee to improvements in the environ working conditions have helped new staff. The facility utilizes all types and digital media as well as helped new staff. The facility utilizes all types and digital media as well as helped new staff. The facility utilizes all types and digital media as well as helped new staff. The facility utilizes all types and digital media as well as helped new staff. The facility utilizes all types and digital media as well as helped new staff. The facility and hire new staff. The facility and hire new staff. The facility core team and manager company and additional incentify provided for working an extra staff. 	salary ative ployees to sonnel with nental grams act and to eviewed ew hires. Int urrent staff. ommittee was improve the xemplary make the station loyee ve opees. onment and d attract of social adhunters eam is ote and	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		03015	B. WING		C 16/2024	
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
AUREL	BROOK REHABILIT	ATION AND HEAL	LAUREL, NJ			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) Comple Date	
S1680	Continued From pa	age 16	S1680	 needed. The success of bonuses and incentives is analyzed by the facility Administrator and Director of Nursing who make recommendations to the QAPI compliance committee at weekly meetings regarding what incentives or bonuses are attracting new hires. Staffing is discussed at daily morning operations meetings and recommendations solicited from the management team about ways to attract new hires to fill vacant positions. Staffing levels of direct care staff and license staff recruitment efforts are discussed daily by nursing management and the administrator, are reported monthly to the corporate clinical team, and are reviewed at the quarterly QAPI committee meetings. Vacancy rates are reviewed weekly by the Director of Nursing and discussed with the Administrator. The effectiveness of strategies to attract and retain staff are discussed and strategies modified as needed. Findings are also discussed monthly with the corporate team that provides direct assistance with recruitment efforts. 		
S2460		ndatory Physical Environment	S2460		11/21/2	
		all have, in their rooms:				
	8. Night lights;					

UBXH11

If continuation sheet 17 of 18

New Jer	sey Department of H	lealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	
		03015	B. WING		C 10/16/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEAL	JRCH ROAD AUREL, NJ			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
S2460	This REQUIREMEN by: Based on observati and 10/10/24 in the Maintenance (DM), Operations (ADPO) Operations Director the facility failed to lights were maintain accordance with N. 8:39-31.2(e). This of potential to affect 2 evidenced by the for Observations during between 11:04 AM between 9:50 AM a 24 resident room no operate. The DM and the surveyor request lights were located 121, 216, 220, 102, In an interview at the RPOD confirmed the The facility's Admin Operations and Re- were informed of the	NT is not met as evidenced fon and interview on 10/09/24 presence of the Director of Assistant Director of Plant and Regional Plant (RPOD), it was determined ensure residents rooms night ned in operational condition in JAC 8:39-31.8(c)(8) and deficient practice had the 4 of 207 residents and was allowing: g a facility tour on 10/09/24 and 2:20 PM and on 10/10/24 and 2:20 PM and on 10/10/24 ind 11:45 AM, revealed 12 of ight lights observed did not and ADPO tested the switch at st. The non-operational night in rooms: 24, 30, 39, 61, 125, 110, 120 and 122. The time, the DM, ADPO and he observations. istrator, Vice President of gional Director of Operations he deficient practice at the Life y exit conference on	S2460	 DEFICIENCY) The 12 of the 24-night lights ide patient room numbers: 24, 30, 39, 125, 121, 216, 220, 102, 110, 120 were repaired on 11/8/24. All Current residents have the p to be affected. A center wide audit performed on 11/8/24 to identify ar current issues with night lights in a patient rooms to ensure all were p functioning. No further findings. The Director of Maintenance ald Maintenance staff were in-serviced 11/8/24 on the proper guidelines in checking night lights in patients r ensure they are properly functionin The Director of Maintenance/de will audit all resident rooms weekly weeks, then monthly x 2 months. T findings of the audits will be submit the Director of Maintenance to the Committee for review and recommendation monthly for 3 mo ongoing until compliance is sustain 	61, and 122 otential was by ill roperly ong with d on b rooms to ng. esignee (x 4 The tted by QAPI onths or	

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVIS	IT
	B. Wing	N	Y2	12/3/2024	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL BROOK REHABILITA	TION 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).

ITE	м		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	¥4			Y 5	Y4			Y5
ID Prefix	F0584		Correction	ID Prefix	F0609	1	Correction	ID Prefix	F0640		Correction
Reg. #	483.10(i)(1)-(7)		Completed	Reg. #	483.12 (1)(4)	2(b)(5)(i)(A)(B)(c)	Completed	Reg. #	483.20(f)(1)-(4)		Completed
LSC			11/21/2024	LSC	(1)(1)		11/21/2024	LSC			11/21/2024
	50045		O a mar a ti a m		50050		O a mar a tha m		50057		0
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.20(k)(1)-(3)	Completed	Reg. #	483.21	(b)(1)(3)	Completed	Reg. #	483.21(b)(2)(i)-((111)	Completed
LSC			11/21/2024	LSC			11/21/2024	LSC			11/21/2024
ID Drofiv	FORED		Correction	ID Prefix	E0604		Correction	ID Prefix	50606		Correction
ID Prefix			Correction				Correction	ID Prefix			Correction
Reg. #	483.21(b)(3)(i)		Completed	Reg. #	483.25		Completed	Reg. #	483.25(b)(1)(i)(i	1)	Completed
LSC			11/21/2024	LSC			11/21/2024	LSC			11/21/2024
ID Prefix	F0689		Correction	ID Prefix	F0690	I	Correction	ID Prefix	F0692		Correction
Reg. #	483.25(d)(1)(2)		Completed	Reg. #	483.25	(e)(1)-(3)	Completed	Reg. #	483.25(g)(1)-(3))	Completed
LSC			11/21/2024	LSC			11/21/2024	LSC			11/21/2024
ID Prefix	F0695		Correction	ID Prefix	F0730)	Correction	ID Prefix	F0732		Correction
Reg. #	483.25(i)		Completed	Reg. #	483.35	(d)(7)	Completed	Reg. #	483.35(g)(1)-(4))	Completed
LSC			11/21/2024	LSC			11/21/2024	LSC			11/21/2024
REVIEW STATE A		REVIEW (INITIAL		DATE		SIGNATURE OF	SURVEYOR			DATE	
REVIEW CMS RO		REVIEW (INITIAL		DATE		TITLE				DATE	
Form CM	IS - 2567B (09/9	2) EF (11	/06)			Page 1 of 2			EVENT ID:	UBXH1	2

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building			DATE OF REVIS	IT
315524 _{Y1}	B. Wing		Y2	12/3/2024	Y 3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL BROOK REHABILITA	TION 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).

ITE		DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0755	Correction	ID Prefix	F0758		Correction	ID Prefix	F0759		Correction
Reg. #	483.45(a)(b)(1)-(3)	Completed	Reg. #	483.45(c)(3)(e)(1)-(5)	Completed	Reg. #	483.45(f)(1)		Completed
LSC		11/21/2024	LSC			11/21/2024	LSC			11/21/2024
ID Prefix	F0761	Correction	ID Prefix	F0791		Correction	ID Prefix	F0812		Correction
Reg. #	483.45(g)(h)(1)(2)	Completed	Reg. #		b)(1)-(5)	Completed	Reg. #	483.60(i)(1)(2)		Completed
LSC		11/21/2024	LSC			11/21/2024	LSC			11/21/2024
ID Prefix Reg. # LSC	F0835 483.70	Correction Completed 11/21/2024	ID Prefix Reg. # LSC		a)(1)(2)(4)(e)(f)	Correction Completed 11/21/2024	_			
REVIEWI STATE A		EVIEWED BY NITIALS)	DATE		SIGNATURE OF	SURVEYOR			DATE	
REVIEWI CMS RO		EVIEWED BY NITIALS)	DATE		TITLE				DATE	
FOLLOW 10/16/20	UP TO SURVEY CO	OMPLETED ON			ANY UNCORRE			A SUMMARY OF HE FACILITY?		5 🔲 NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
03015 _{Y1}	B. Wing	,	Y2	12/3/2024	Y 3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL BROOK REHABILITA	TION AND HEALTHCARE CENTER	3718 CHURCH ROAD			
		MOUNT LAUREL, NJ 08054			

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ITEI Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
14		10	14		10	14		10
ID Prefix	H5790	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	8:43E-13.4(d)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		11/21/2024						
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		·						
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		
REVIEWE STATE AC		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF	SURVEYOR	I	DA	ΓE
REVIEWE CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE			DA	TE
FOLLOW 10/16/20		Y COMPLETED ON		OR ANY UNCORREC				YES 🗌 NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
03015 _{Y1}	B. Wing		Y2	12/3/2024	Y 3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL BROOK REHABILITA	TION 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).

ITEI Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		I	DATE Y5
ID Prefix Reg. # LSC		Correction Completed 11/21/2024	ID Prefix	S1680 8:39-25.2(b)(1)&(2)	Correction Completed 11/21/2024	ID Prefix Reg. # LSC	S2460 8:39-31.8(c)(8)	с	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC			Correction
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC			correction
		REVIEWED BY (INITIALS) REVIEWED BY (INITIALS) Y COMPLETED ON		SIGNATURE OF TITLE			A SUMMARY OF	DATE	
10/16/20)24		UNCO	ORRECTED DEFICIENC	IES (CMS-2567)	SENT TO T	HE FACILITY?	YES	NO NO

		AND HUMAN SERVICES			FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT			. 0938-0391 E SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN			IPLETED
		315524	B. WING _		10/	16/2024
NAME OF F	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE		3718 CHURCH ROAD		
				MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	ю		
K 000	Appendix Z-Emerge Provider and Suppl		к ос	ю		
	New Jersey Depart Survey and Field O 10/09/2024 and 10/ Rehabilitation and H to be in noncomplia participation in Med 483.90(a), Life Safe Edition of the Fire F	Survey was conducted by the ment of Health, Health Facility perations on 10/08/2024, /10/2024 and Laurel Brook Healthcare Center was found ance with the requirements for licare/Medicaid at 42 CFR ety from Fire, and the 2012 Protection Association (NFPA) de (LSC), Chapter 19 Care Occupancies.				
	stated to be around renovations or note building Type II (00 sprinklered. The bu gas generators 30 a approximately 60% 2-elevators have fir	building construction was I 1990's with no current major ad additions. It is a two story 0) construction and is fully ilding utilizes 2-interior natural and 85 KW and does of the building. The e sprinkler protection at the each shaft as per the				
	the corridors, space resident rooms. The is stated to be tied to cross corridor door door releases, eme	d smoke detection located in es open to the corridors and in e generator outside the facility to the fire alarm control panel, hold open devices, exterior ergency facility lighting and life utilized for preservation of life				
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					11/08/2024

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.

		AND HUMAN SERVICES			FORM	: 03/31/202 1 APPROVEI . 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE			TE SURVEY
		315524	B. WING	;	10	/16/2024
	PROVIDER OR SUPPLIER	ATION AND HEALTHCARE CENTI	ER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 718 CHURCH ROAD MOUNT LAUREL, NJ 08054	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From pa	ige 1	ĸ	000		
K 293 SS=F	the survey the cens Exit Signage) certified beds. At the time of sus was 207.	ĸ	293		11/21/24
	accordance with 7. also served by the of 19.2.10.1 (Indicate N/A in one with less than 30 of travel is obvious.) This REQUIREMEN by: Based on observat 10/09/2024 in the p 10/09/2024 in the p), that the facility faile exit and directional accordance with NF 19.2.10.1 and 7.10. the potential to affe evidenced by the for An observation at 2 from the closed cou In an interview at the """"" confirmed the The facility's U.S. FO and U.S.	2:02 PM revealed the exit door urtyard had no exit sign. The time, the DEFECT DEFECTION and the observation. DIA (b) (6) U.S. FOIA (b) (6) 5. FOIA (b) (6) the deficient practice at the Life			 An exit sign was installed from the closed courtyard on 11/4/24. All residents have the potential to be affected. <u>U.S. FOIA (b) (6)</u> was educated on 11/8/24 by VP of Plant Operations, on ensuring all exit signs are in proper location and functioning properly in accordance of NFPA 101:2012 edition Section 19.1.10 and 7.10. The Plant Operation Manager/designee will conduct exit signage audits weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained. 	5

Event ID: UBXH21

Facility ID: NJ03015

If continuation sheet Page 2 of 14

		AND HUMAN SERVICES	-			FORM	03/31/2025 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mui A. Buile		CONSTRUCTION 1	· ·	E SURVEY IPLETED
		315524	B. WING			10/	16/2024
	PROVIDER OR SUPPLIER	ATION AND HEALTHCARE CENT	ĒR	371	REET ADDRESS, CITY, STATE, ZIP CODE 18 CHURCH ROAD DUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 293	Safety Code survey 10/10/2024 at 2:58	y exit conference on PM.	K	293			
K 321 SS=F	N.J.A.C 8:39-31.2(Hazardous Areas - CFR(s): NFPA 101		K	321			11/21/24
	having 1-hour fire r fire rated doors) or system in accordar When the approved system option is us separated from oth partitions and doors Doors shall be self- and permitted to ha protective plates th from the bottom of Describe the floor a hazardous areas th 19.3.2.1, 19.3.5.9 Area Separation N// a. Boiler and Fuel-F b. Laundries (larger c. Repair, Maintena d. Soiled Linen Roo e. Trash Collection (exceeding 64 gallo f. Combustible Stor (over 50 square fee g. Laboratories (if of Hazard - see K322	re protected by a fire barrier esistance rating (with 3/4 hour an automatic fire extinguishing nee with 8.7.1 or 19.3.5.9. d automatic fire extinguishing sed, the areas shall be er spaces by smoke resisting s in accordance with 8.4. -closing or automatic-closing ave nonrated or field-applied at do not exceed 48 inches the door. and zone locations of nat are deficient in REMARKS. Automatic Sprinkler A Fired Heater Rooms r than 100 square feet) ance, and Paint Shops oms (exceeding 64 gallons) Rooms ons) rage Rooms/Spaces et) classified as Severe					

Facility ID: NJ03015

If continuation sheet Page 3 of 14

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			FC OMB	red: 03/31/20 DRM APPROV NO: 0938-03
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE			DATE SURVEY COMPLETED
		315524	B. WING	;		10/16/2024
NAME OF I	PROVIDER OR SUPPLIER	-		I .	STREET ADDRESS, CITY, STATE, ZIP CODE	
LAUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	I .	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
K 321	10/09/24 and 10/10 U.S. FOIA (b) (6) that the facility faile areas were protects accordance with NF Sections 19.3.2, 19 practice had the por residents and was of An observation on a revealed the north j close into its frame open position. The same results. The r supplies and boxes An observation on a 10:22 AM, revealed door did not close in from the fully open and stopped 2-inch test was repeated v In an interview at the Section on a self of 180 degree open por contained combust In an interview at the	tions and interviews on (24 in the presence of the), U.S. FOIA (b) (6)) and U.S. FOIA (b) (K	321	 The Janitor Closet door on the Nor Unit was adjusted to positively latch int the frame and was completed on 11/4/2 The Janitor Closet door on the East Ur was adjusted to positively latch into the frame and was completed on 11/4/24. / self-closing device was installed to the kitchen dry storage room on 11/5/24 to always ensure the door closes and latches properly. " U.S. FOIA (b) (6) was educated on 11/8/24 by VP of Plant Operations, on requirements for hazardous areas in accordance with NFPA 101: 2012 Edition Section 19.3.2 19.3.5.9 and 8.4. Kitchen staff were educated on 11/8/24 on hazardous door requirements and always ensuring prop closure of doors. The Plant Operation Manager conducted a center wide audi on 11/8/24 to inspect all hazardous are doors. " The Plant Operation Manager/designee will conduct hazard area door audits weekly x 4 weeks, the monthly x 2 months. The findings of the audits will be submitted by the Administrator to the QAPI Committee f review and recommendation monthly for months or ongoing until compliance is sustained. 	o 24. hit A be be be c per hit a ous en e or
		ne observation.				
	The facility's 0.5. FO	IA (b) (6) U.S. FOIA (b) (6)				

Facility ID: NJ03015

If continuation sheet Page 4 of 14

		AND HUMAN SERVICES	-		F	ORM	03/31/2025 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD				E SURVEY PLETED
		315524	B. WING			10/1	6/2024
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	ATION AND HEALTHCARE CENTE	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 321	U.S. FOIA (b) (b) were informed of th Life Safety Code su 10/10/2024 at 2:58	6. FOIA (b) (6) ne deficient practices at the urvey exit conference on PM.	KS	21			
	CFR(s): NFPA 101 Sprinkler System - Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspe- maintained in a sec available. a) Date sprinkler s b) Who provided s c) Water system s Provide in REMARI any non-required of system. 9.7.5, 9.7.7, 9.7.8, a This REQUIREMEN by: Based on observat and 10/10/24 in the system.	Maintenance and Testing Maintenance and Testing and standpipe systems are and maintained in accordance dard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily system last checked system test supply source KS information on coverage for r partial automatic sprinkler	K	53	" A sprinkler head escutcheon was installed on 11/5/24 in the North Nurs bathroom ceiling. Two escutcheon pla were installed in the North day room. escutcheon was adjusted in the North dining by the TV on 11/5/24. Two escutcheon plates were installed on	se ates An	11/21/24

Event ID: UBXH21

Facility ID: NJ03015

If continuation sheet Page 5 of 14

		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build		e construction 01	· · ·	E SURVEY PLETED
		315524	B. WING			10/*	16/2024
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		TION AND HEALTHCARE CENTE		3	718 CHURCH ROAD		
LAUREL	BROOK REHABILIT	TION AND REALTHCARE CENTE	-R	N	IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 353	Continued From pa	ae 5	K S	353			
	edition, Sections 9. 2011 edition. This of potential to affect a evidenced by the for Observations during 10/09/24 between 9 revealed the followi 1. The sprinkler eso nurses station bath 2. Two of the 6 spri escutcheons in the	7.5, 19.3.5.1, and NFPA 25: leficient practice had the ll 207 residents and was blowing: g a tour of the facility on l1:04 AM and 2:20 PM and on 0:50 AM and 11:45 AM ng: cutcheon was missing in north room ceiling. nkler heads were missing north day room. g room, the escutcheon on the			11/5/24 in the Director of Korean at Office. A new ceiling tile was instal 11/8/24 to seal the 4x3 inch gap in north storage closet. An Escutched installed on 11/5/24 in Resident roo The one-inch gap around two sprin pipes in the linen closet by resident 74 was sealed on 11/8/24 with an U rated intumescent fire caulk stop g system. The ¿ inch gap around two sprinkler pipes in the supply closet resident room 60 was sealed on 11 with an UL rated faire caulk stop gas system. The back wall of the east win Janitor Closet will was sealed on 11 with an UL rated fire caulk stop gap system. A new ceiling tile was insta 11/8/24 to seal the 5 inch x 3 inch fire	lled on the 2 on was om 31. kler t room JL ap by 1/8/24 ap inkler ng 1/8/24 o alled on	
	sprinkler heads had leaving a 1-inch spa in the drywall ceiling 5. In the 2 north sto station, there was a drop ceiling around	orage closet by the nurses 4-inch by 3-inch cut out in the the sprinkler head. 31, the escutcheon was			the drop ceiling around the white pl above and into the milk box. The Conditioning vent was removed on 11/8/24, and the rated ceiling tile w back into the ceiling tack assembly Maintenance Shop. An Escutcheor was installed on 11/5/24 in the wes dining room. " All residents have the potential affected. " U.S. FOIA (b) (6) was	Air as put in the n plate it wing to be	
	were 2 sprinkler pip closet space by the space around the p 8. In the supply clos were 2 sprinkler pip	t by resident room 74, there bes that entered and exited the ceiling, each had a 1-inch ipe on each side. Set by resident room 60, there bes that entered and exited the ceiling, each had a 1/2 -inch			educated on 11/8/24 by VP of Plan Operations, on maintaining the spr system and ensuring the ceiling lev smoke resistance in accordance w NFPA 101,2012 Edition Section 5.2.1.1.1(2). The Maintenance Stat educated on Sprinkler System Maintenance and testing requirement accordance with NFPA 101,2012 E	inkler vel is ith ff was ents in	

Facility ID: NJ03015

If continuation sheet Page 6 of 14

		AND HUMAN SERVICES			FORM	: 03/31/2025 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG 01		re Survey Mpleted
		315524	B. WING_		10	/16/2024
	PROVIDER OR SUPPLIER	ATION AND HEALTHCARE CENT	ER	STREET ADDRESS, CITY, S 3718 CHURCH ROAD MOUNT LAUREL, NJ		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE IED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
	pipe in the back wa 10. In the housekee a 5-inch by 3-inch h a black sprinkler pip 5-inch hole in the d pipe. The pipes we milk box. 11. In the maintena by 2-foot ceiling tile where air condition from the room. The and hot gases to flo preventing the sprint their designed time 12. In the west wing plate was missing of In an interview at the SFOCTOR confirmed the The facility's U.S. FOCTOR	ipe on each side. ianitors closet, the sprinkler ill had a space around it. eping storage room, there was hole in the drop ceiling around pe and there was 2-inch by rop ceiling around a white re above and went into the ance shop, there was a 2-foot missing in the drop ceiling ing exhaust was being vented to opening would allow smoke ow into the space above hklers from being activated at and temperature. g dining room, the escutcheon on 1 of 8 sprinkler heads. he time, the USEON USEON (b) (6) S. FOIA (b) (6) b. FOIA (b) (6) b. FOIA (b) (6)	К 3	53 Section 9.7.5 19.3. edition. The Plan O completed an audi system and ceiling " The Plant Ope Manager/designee system an ceiling a weeks, then month findings of the aud the Administrator to for review and reco for 3 months or on is sustained	.5.1 and NFPA 25:2011 Dperation manager it on the sprinkler is on 11/8/24. eration e will conduct sprinkler	11/21/24
	i67(02-99) Previous Versions	Obsolete Event ID: UBXH2		Facility ID: NJ03015	If continuation shee	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILING 01 (X2) (X1) DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILING 01 (X2) (X1) DENTIFICATION NUMBER: (X3) (X1) DENTIFICATION NUMBER: (X3) DENTIFICATION NUMBER: (X3) DENTIFICATION NUMBER: (X3) DENTIFICATION NUMB			AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE MAINT TAGE SUMMARY STATEMENT OF DEFICIENCIES ID PREVIX RESOLATORY OR LSC IDENTIFYING INFORMATION) PREVIX RESOLATORY OR LSC IDENTIFYING INFORMATION) K 363 Continued From page 7 K 363 K 363 Continued From page 7 K 363 mad re made of 1 34 inch solid-bonded core K 363 wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke and are made of 134 inch solid-bonded core K 363 materials have positive latching hardware. Roller Iatches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearace between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no mixed protective plates of unlimited height are permitted. Door frames shall be labeled and made of steel or other materials in complarment is sprinklered. Fixed fire window assemblies. 19.3.6.3.42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Stall 400000000000000000000000000000000000						(X3) DATE SURVEY COMPLETED		
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054 (X4) ID HYAX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROTEX TAG PROVIDENS FLAN OF CORRECTION (EACH DEFICIENCY) K 363 Continued From page 7 Doors protecting corridor openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prolibited by CMS regulation. These requirements do not apply to auxillary spaces that do not contain flammable or combustible materials have positive latching hardware. Roller latches are prolibiled by CMS regulation. These requirements do not apply to auxillary spaces that do not contain flammable or is pushed or pulled are permitted. Norated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Dutch doors meeting 19.3.6.3.42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			315524	B. WING			10/	16/2024
Preferx Tvg (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX Tvg (EACH DEFICIENCY AND ST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) K 363 Continued From page 7 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible materials in a cozeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of the door is pushed or pulled are permitted. Unch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Image: Carole and seven as a site of such as fire protection ratings, automatics closing devices, etc.			ATION AND HEALTHCARE CENTE	ER	3718	CHURCH ROAD		
 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dourd frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
by: Based on observation and interview on 10/09/24 " The resident room doors to room	K 363	Doors protecting correquired enclosures hazardous areas reand are made of 1 wood or other material at least 20 minutes smoke compartment the passage of smoother to rooms containing materials have posi- latches are prohibit requirements do no do not contain flam Clearance between covering is not exce complying with 7.2. with a device capate when a force of 5 lk impediment to the of devices that release pulled are permitted of unlimited height meeting 19.3.6.3.6 shall be labeled and materials in complia smoke compartment window assemblies sprinklered compar restrictions in area frames in window a 19.3.6.3, 42 CFR P and 485 Show in REMARKS protection ratings, a etc. This REQUIREMEN	brridor openings in other than s of vertical openings, exits, or esist the passage of smoke 3/4 inch solid-bonded core erial capable of resisting fire for . Doors in fully sprinklered ints are only required to resist oke. Corridor doors and doors g flammable or combustible itive latching hardware. Roller ed by CMS regulation. These of apply to auxiliary spaces that mable or combustible material. a bottom of door and floor eeding 1 inch. Powered doors 1.9 are permissible if provided of keeping the door closed of is applied. There is no closing of the doors. Hold open e when the door is pushed or d. Nonrated protective plates are permitted. Dutch doors are permitted. Door frames d made of steel or other ance with 8.3, unless the nt is sprinklered. Fixed fire are allowed per 8.3. In timents there are no or fire resistance of glass or assemblies. Parts 403, 418, 460, 482, 483, 6 details of doors such as fire automatics closing devices, NT is not met as evidenced	K		' The resident room doors to	rooms 23,	

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		AND HUMAN SERVICES				FORM	03/31/2025 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mult A. Buildi		(X3) DATE SURVEY COMPLETED		
		315524	B. WING			10/ [.]	16/2024
NAME OF	PROVIDER OR SUPPLIER		· · · · · ·		REET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	ATION AND HEALTHCARE CENT	ER		8 CHURCH ROAD DUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 363 K 374 SS=F	and 10/10/24 in the that the facility faile closed and latched with NFPA 101: 201 19.3.2.1, 19.3.2.1.3 19.3.7.9 and NFPA deficient practice has residents and was Observations during 10/09/24 between 2 10/10/24 between 2 revealed 3 of 26 reso observed (rooms 22 into their frames and In an interview at the Safety Code survey 10/10/2024 at 2:58 N.J.A.C 8:39-31.2(e NFPA 80 Subdivision of Build CFR(s): NFPA 101	e presence of the US FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6) it was determined d to ensure corridor doors into their frame in accordance 12 edition, Section 19.3.6.3, 3, 19.3.5.9, 19.3.7.6, 19.3.7.8, A 80: 2010 Edition. This ad the potential to affect 207 evidenced by the following: g a tour of the facility on 11:04 AM and 2:20 PM and on 2:50 AM and 11:45 AM, sident room corridor doors 3, 76 and 216) did not close ad latch. the time, the US FOM US FOM (D) 5. FOIA (b) (6) D.S. FOIA (b) (6) be deficient practice at the Life y exit conference on PM.	К 3		76 and 216 were adjusted on 11/4/2 doors to close and latch in their fram accordance with the requirements o NFPA 101,2012 Edition, Section 19. 19.3.2.1, 19.3.2.1.3, 19.3.5.9, 19.3.7 19.3.7.8, 19.3.7.9, and NFPA 80; 20 Edition. " All residents have the potential the affected. " <u>U.S. FOIA (b) (6)</u> was educated on 11/8/24 by the VP of PI Operations, on the requirements of 101,2012 Edition, Section 19.3.6.3 19.3.2.1, 19.3.2.1.3, 19.3.5.9, 19.3.7 19.3.7.8, 19.3.7.9, and NFPA 80; 20 Edition. Plant Operations Manager completed an audit on all doors and frames in the facility on 11/8/24 ensu they in accordance with requirement NFPA 101,2012 Edition, to close and properly into the door frame. " The Plant Operation Manager/designee will conduct an a all facility doors ensuring they in accordance with requirements of NF 101,2012 Edition, to close and latch properly into the door frame weekly weeks, then monthly x 2 months. The findings of the audits will be submitted the Administrator to the QAPI Comm for review and recommendation mon for 3 months or ongoing until compli is sustained	nes in f 3.6.3 7.6, 010 to be ant NFPA 7.6, 010 uring ts of d latch uudit of FPA x 4 ne ed by nittee nthly	11/21/24

Facility ID: NJ03015

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			FC OMB	TED: 03/3 ORM APPI NO: 093	ROVED 8-0391	
				TIPL ING		(X3) DATE SURVEY COMPLETED		
		315524	B. WING			10/16/20)24	
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL	BROOK REHABILITA	ATION AND HEALTHCARE CENT	R		718 CHURCH ROAD IOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	COM	(X5) Pletion Date	
K 374	2012 EXISTING Doors in smoke bar bonded wood-core resists fire for 20 m plates of unlimited l are permitted to ha assemblies per 8.5 automatic-closing, o are not required to egress travel. Door clear width of 32 ind doors. 19.3.7.6, 19.3.7.8, This REQUIREMEN by: Based on observat 10/09/24 and 10/10 U.S. FOIA (b) (6) that the facility faile doors closed into th from their hold oper only the minimum of operation to resist t 16 smoke barrier do with NFPA 101: 201 19.3.7 to 19.3.7.9, 8 2010 Edition. This potential to affect 2 evidenced by the for An observation on revealed the North double doors' left do way into its frame w	rriers are 1-3/4-inch thick solid doors or of construction that inutes. Nonrated protective height are permitted. Doors ve fixed fire window . Doors are self-closing or do not require latching, and swing in the direction of opening provides a minimum ches for swinging or horizontal 19.3.7.9 NT is not met as evidenced tions and interview on 24 in the presence of the 1, U.S. FOIA (b) (6) 1) ancU.S. FOIA (b) (6) 1) ancU.S. FOIA (b) (6) 1), it was determined d to ensure smoke barrier heir door frame when released in devices or closed leaving clearance necessary for proper he passage of smoke for 5 of oors observed in accordance 12 Edition, Section 19.3.6.3, 8.5.4, 8.5.4.1 and NFPA 80: deficient practice had the 07 residents and was	K	374	• The smoke barrier double doors of the North 2 long hall were adjusted to allow the doors to close tight within the frame. The repair was completed on 11/18/24. The smoke barrier double do in the Central Hall by the vending machines had the right leaf door adjuss by installing longer screws into the hing so the door closes and latches into the frame accordingly. A UL-rated astragal that closes the identified gaps vertically between the doors was installed on 11/18/24 on the double smoke barrier doors by room 53. A rated door sweep was installed on the bottom of the door on 11/18/24 to eliminate the gap that w present during the life safety inspection that occurred on 10/9/24. A UL-rated astragal that closes the identified gaps vertically between the doors was install on 11/18/24 on the double smoke barri doors to the East 2 service hall doors. rated door sweep was installed on the bottom of the doors to eliminate the gap	e oors sted ge e il ly vas vas n s lled rier A		

Facility ID: NJ03015

		AND HUMAN SERVICES				FORM	03/31/202 APPROVED 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		e construction 01		E SURVEY PLETED
		315524	B. WING			10/1	16/2024
NAME OF	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	ATION AND HEALTHCARE CENTE	ER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 374	An observation on the central hall to ve double doors' right when released from right door leaf mag was loose and hang test was repeated 5 not closing 3 of the door leaf mechanis An observation on the double smoke b 3/4-inch space betw and brush type astr 1/4-inch to 1/8-inch vertically from the fib brushes. An observation on the observation on the brushes. An observation on the closing the space be and had a 3/16-inch between the astrag 1/2 the distance of An observation on the corridor smoke stopped 1-inch from frame when release The test was repeat results. In an interview at the The facility's U.S. FO and U.S.	10/09/24 at 1:11 PM, revealed ending area smoke barrier leaf did not close to the frame in its fully open position. The lock holding the door closed ging in a crooked position. The badditional times with the door 6 total tests indicating the m was not reliable. 10/10/24 at 9:50 AM, revealed barrier doors by room 53 had a ween the doors meeting edges ragals closing the space with gap running 48 inches loor up between the astragal 10/10/24 at approximately the East 2 service hall smoke s had brush type astragals between the meeting edges in gap running vertically al edges from the bottom up the door edges. 10/10/24 at 10:30 AM revealed door to the service area hall in its proper place in the door ed from its fully open position. ted 2 times with the same	K3	374	that was present during the life safe inspection that occurred on 10/9/24 corridor smoke door to the service beyond repair and needs to be rep We requested a Time-limited waive the door due to manufacturing dela The door was ordered on 11-8-24 v ETA of 3/15/24 for installation. • All residents have the potential affected. • U.S. FOIA (b) (6) was educated on 11/8/24 by the VP of F Operations, on required Smoke Ba door Operations. Plant Operations manager conducted an audit on 11 all smoke doors to ensure all smoke doors in corridors properly close ar into the frame. • The Plant Operation Manager/designee will conduct an all smoke doors to ensure all smoke doors in corridors properly close ar into the frame of all facility doors en they in accordance with requirement NFPA 101,2012 Edition, to close an properly into the door frame weekly weeks, then monthly x 2 months. T findings of the audits will be submit the Administrator to the QAPI Com for review and recommendation mo for 3 months or ongoing until comp is sustained	 The hall is laced. aced. ar for ays. with an to be Plant arrier /8/24 of a latch audit a latch audit a latch audit a latch x 4 a latch ke a latch y x 4 a latch auditee by mittee onthly 	

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		AND HUMAN SERVICES	-		FC	DRM	03/31/2025 APPROVED 0938-0391
			(X2) MUL A. BUILD		· · ·	(X3) DATE SURVEY COMPLETED	
315524			B. WING			10/1	6/2024
NAME OF F	PROVIDER OR SUPPLIER	I	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL	BROOK REHABILITA	ATION AND HEALTHCARE CENTI	ER		718 CHURCH ROAD OUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E	(X5) COMPLETION DATE
K 374		exit conference on	К 3	574			
		, and air conditioning shall d shall be installed in	К 5	521			11/21/24
	by:	NT is not met as evidenced					
	and 10/10/24 in the the facility failed to exhaust fans were condition in accord edition, Sections 19	tion and interview on 10/09/24 presence of the U.S. FOIA (b) (6) U.S. FOIA (b) (6) it was determined ensure residents bathroom maintained in operational ance with NFPA 101:2012 0.5.2.1, 9.2. This deficient tential to affect 207 residents by the following:			 The exhaust fans to resident room bathrooms were ordered on 11/5/24 ar will be completed by 11/21/24 to ensur proper air flow for exhaust in Resident rooms 15,36,37,38,39,40,41,42,43,44,45,46,4 8,49,50 and 51 in accordance with NFI 101: 2012 Edition sections 19.5.2.1,9.2 All residents have the potential to b affected. U.S. FOIA (b) (6) was educated on 11/8/24 by the VP of Plan 	nd re 47,4 PA 2. be	
	between 11:04 AM between 9:50 AM a 26 resident room ba have windows and	g a facility tour on 10/09/24 and 2:20 PM and on 10/10/24 and 11:45 AM, revealed 18 of athrooms observed did not the exhaust fans did not athrooms tested the fans at			 Operations, on inspecting the operation bathroom exhaust fans per code. The Plant Operation Manager/Designee will conduct an auc on all the bathroom exhaust fans for proper ventilation weekly x 4 weeks, the 	n of dit	

Event ID: UBXH21

Facility ID: NJ03015

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		AND HUMAN SERVICES				FORM	03/31/2028 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		r		E SURVEY PLETED
		315524	B. WING			10/ [,]	16/2024
	PROVIDER OR SUPPLIER	TION AND HEALTHCARE CENT	ER	37	REET ADDRESS, CITY, STATE, ZIP CODE 18 Church Road Ount Laurel, NJ 08054		
<mark>(</mark> X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
	the surveyor requese exhaust fans were 38, 39, 40, 41, 42, 4 and 51. In an interview at the confirmed the Dementia Unit the exhaust fan for the served by that unit The facility's U.S. FO and U.S. were informed of the Safety Code survey 10/10/2024 at 2:58 N.J.A.C 8:39-31.2(6 NFPA 90A Electrical Systems CFR(s): NFPA 101 Electrical Systems List in the REMARK Chapter 6 Electrica are not addressed are deficient. This in applicable Life Safe citation, should be in Chapter 6 (NFPA 99 This REQUIREMENT by: Based on observation and 10/10/24, in the	 a. The non-operational located in rooms: 15, 36, 37, 43, 44, 45, 46, 47, 48, 49, 50 b. time, the store store and the observation. In the store and the observation. In the store and the observation. In the store and the bathrooms will not work. b. FOIA (b) (6) U.S. FOIA (b) (6) c. FOIA (b) (6) c. FOIA (b) (6) deficient practice at the Life vexit conference on PM. e) c. Other Section any NFPA 99 I Systems requirements that by the provided K-Tags, but information, along with the ety Code or NFPA standard included on Form CMS-2567. 	К 5		monthly x 2 months. The findings of audits will be submitted by the Administrator to the QAPI Committee review and recommendation monthly months or ongoing until compliance is sustained " The electrical wall panel in the corridor next to the North nurses□ st along with the three electrical wall pain the corridor next to the double smoothing in the corridor next to the double	e for y for 3 is tation, anels es panel	11/21/24

Event ID: UBXH21

Facility ID: NJ03015

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	OMB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN			PLETED
		315524	B. WING		10/	16/2024
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
AUREL	BROOK REHABILITA	TION AND HEALTHCARE CENTE	R	3718 CHURCH ROAD MOUNT LAUREL, NJ 080	54	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) Completic Date
K 911	Continued From pa	-	K 91			
	unlocked electrical area for 4 of 11 electrical	ent and controls within an panel in a resident accessible ctrical panels observed, in		doors by room 53 was completed immediate 10/10/24.	ly at finding on	
	19.5.1.1, 9.1.2, NFI	FPA 101, 2012 Edition, Section PA 99 2012 Edition, Section d NFPA 70 2011 Edition,		affected. "U.S. FOIA (b) (6)	the potential to be was	
		0.27 and 110.16. This deficient tential to affect 207 residents by:		educated on 11/8/24 k Operations, on NFPA section 19.5.1.1, 9.1.2	101: 2012 edition 2, NFPA 99 2012	
	10/09/24 between 1	g a tour of the facility on 1:04 AM and 2:20 PM and on 0:50 AM and 11:45 AM		edition, section 6.3.2. NFPA 70 2011 Edition 100.27 and 110.16ass Electrical panel boxes times per code. The P	, section 110.26, suring that all are locked at all Plant Operation	
		panel in the corridor next to ation was not locked.		Manager audited the e boxes on 11/8/24 to as panels are properly lo "The Plant Operati	ssure all electrical cked. ons	
		vall panels in the corridor th nurses station were not		Manager/designee wil on all electrical panel weeks, then monthly findings of the audits	boxes weekly x 4 < 2 months. The	
		panel in the corridor next to loors by room 53 was not		the Administrator to th for review and recomm for 3 months or ongoin is sustained.	mendation monthly	
	In an interview at th	e time, the used used and and a observation.		lo ouotamou.		
	and U.S were informed of th	IA (b) (6) U.S. FOIA (b) (6) 5. FOIA (b) (6) e deficient practice at the Life (exit conference on PM.				
	N.J.A.C 8:39-31.2(6 NFPA 70	e)				

Facility ID: NJ03015

If continuation sheet Page 14 of 14

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - LAUREL BROOK REHABI	DATE OF REVI	SIT					
315524 _{Y1}	B. Wing	-						
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE						
LAUREL BROOK REHABILITA	TION 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).

ITE	М	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y 5	Y4			Y5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #	NFPA 101		Completed
LSC	K0293	11/21/2024	LSC	K0321		11/21/2024	LSC	K0353		11/21/2024
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #	NFPA 101		Completed
LSC	K0363	11/21/2024	LSC	K0374		11/21/2024	LSC	K0521		11/21/2024
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #			Completed	Reg. #			Completed
LSC	K0911	11/21/2024	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			
REVIEW		REVIEWED BY (INITIALS)	DATE		SIGNATURE OF	SURVEYOR			DATE	
REVIEW CMS RO		REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOW 10/16/20		Y COMPLETED ON			ANY UNCORREC					s 🔲 NO