	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		315524	B. WING		C 06/01/2023		
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 00				
F 000	Appendix Z-Emergen Provider and Supplier Guidance 483.73, Re Care (LTC) Facilities. INITIAL COMMENTS	quirements for Long Term	F 00	0			
	160664; 161353; 161	618; 159650; 160150; 540					
	Survey Date: 6/1/23 Census:196						
	Sample: 35 + 5 + 2						
F 609 SS=D		e with 42 CFR Part 483, ng Term Care Facilities. ed for this survey. Violations	F 60	9		6/12/23	
		se to allegations of abuse, or mistreatment, the facility					
	involving abuse, negli mistreatment, includir source and misappro are reported immedia hours after the allegat that cause the allegat serious bodily injury,	that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, itely, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if the allegation do not involve					
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE 06/16/202	

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.

			0.00			10.0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	TE SURVEY MPLETED
			A. BUILDING	3		С
		315524	B. WING			6/01/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		0/01/2023
				3718 CHURCH ROAD	0002	
AUREL E	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		MOUNT LAUREL, NJ 08054		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETIO
F 609	Continued From pag	e 1	F 60)9		
		sult in serious bodily injury, to				
		he facility and to other				
		the State Survey Agency and				
		ces where state law provides				
		g-term care facilities) in				
	procedures.	te law through established				
	§483.12(c)(4) Report	t the results of all				
		administrator or his or her				
		tative and to other officials in				
		te law, including to the State				
		in 5 working days of the leged violation is verified				
		e action must be taken.				
		T is not met as evidenced				
	by:					
		on, interview, and review of		F609 Reporting of Allege		
		uments, it was determined		CFR(s): 483.12(b)(5)(i)(A)		
		to report to the New Jersey h (NJDOH) an allegation of		483.12(c) In response to a	0	
	NJ Exec Order 2	, č		abuse, neglect, exploitation mistreatment, the facility r		
	Resident #72 and #1			(1) Ensure that all alleged		
		e was identified for 1 of 2		involving abuse, neglect,		
		ions reviewed, and was		mistreatment, including in	•	
	evidenced by the foll	owing:		unknown source and misa		
				resident property, are rep		
	0n 5/22/23 at 12·28	PM, the surveyor observed		immediately, but not later after the allegation is mad		
		in their room. Resident #72		that cause the allegation i		
	informed the surveyo	or that on ^{NJ Exec Order 26.4b1}		result in serious bodily inju		
		in a ^{NJ Exec Order 26.4b1}		than 24 hours if the event		
		vith their roommate		allegation do not involve a		
		sident #72 reported that		result in serious bodily inju	-	
		peaking with their Nurse d the NP asked Resident		administrator of the facility officials (including to the S		
		ch the resident did not		Agency and adult protecti		
	-	Resident #72) answered the		where state law provides		
		dent #72 continued that		long term care facilities) ir		

Facility ID: NJ03015

If continuation sheet Page 2 of 31

		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	. ,	TE SURVEY MPLETED
					С	
		315524	B. WING			6/01/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	° CODE	
LAUREL I	BROOK REHABILITATIO	ON AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	OF CORRECTION	(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	D THE APPROPRIATE	COMPLETIC
F 609	Continued From pag	je 2	F 60	09		
	Resident #146 beca			with State law through es	tablished	
	NJ Exec Order 2			procedures. 483.12(c)(4)		
				results of all investigation	is to the	
		Resident #72 stated multiple		administrator or his or he		
	staff were involved to	o ^{NJ Exec Order 26.4b1} , and a		representative and to oth		
		le (CNA) ^{NJ Exec Order 26.4b1}		accordance with State law		
	, an NJ Exec Order 26.4b1	d stated the CNA saw that Resident #72 reported that		the State Survey Agency days of the incident, and	÷	
	Resident #146 was	moved that day		violation is verified appro		
		noved that day.		action must be taken.		
	The surveyor review	ed the medical record for		1. Residents # 72 & 146	were evaluated	
	Resident #72.			and had NJ Exec Orde	r 26.4b1	
				The incide	ent was reported	
		ission Record face sheet (an		to the NJ Department of I		
) reflected the resident was		. Investigation w		
	admitted to the facili	ty in ^{NJ Exec Order 26.4b1} , with		and the completed summ		
	diagnoses which inc	luded NJ Exec Order 26.4b1		conclusion was emailed t		
				Department of Health on 2. All cases of residents v		
				of abuse, neglect or misa		
	A review of the most	recent quarterly Minimum		have the potential to be a		
		assessment tool dated		deficient practice. The NI	-	
		brief interview for mental		cases of residents with al		
	status (BIMS) score	of out of 15, which		abuse, neglect, or misap		
	indicated aNJ Exec C	order 26.4b1		assure that identified cas		
				timely to the state licensir		
		ress Notes did not include		3. The DON/designee re-		
	the incident from	·		interdisciplinary team, Nu on the "Abuse, Neglect, E		
	The survevor review	ed the medical record for		Misappropriation". This for		
	Resident #146.			facility's responsibility to e		
				violations involving misap		
		ission Record face sheet		neglect, and/or abuse are	-	
		t was admitted to the facility		reported to the Administra		
		diagnoses which included		respective state agencies		
	NJ Exec Order 2	0.401		4. The NHA/designee will		
				reports, grievances and in daily X5 weekly x4 and m	-	
		•		ensure all allegations of	IONITINY AS LO	

If continuation sheet Page 3 of 31

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/05/2024 MAPPROVED D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		COMF	E SURVEY PLETED	
		315524	B. WING				01/2023
	ROVIDER OR SUPPLIER BROOK REHABILITATIO	N AND HEALTHCARE CENTER	·	37	TREET ADDRESS, CITY, STATE, ZIP CODE 718 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	A review of the admis reflected a BIMS scor indicated a NJ Exec O A review of the Progra the incident from Don 5/23/23 at 10:49 A Home Administrator (Nursing (DON) provid investigations for Res admission. This did r NJ Exec Order 20 On 5/23/23 at 12:32 F Resident #146 who si changed on Resident # 146 who si changed on Resident # 146 stated every tim someone, Resident # conversation to speak # 146 continued on # 146 continued on NJ Exec Order 20 WING ON PROVIDENT at the time On 5/24/23 at 8:33 AT DON if the facility inve occurred on	sion MDS dated with of the surveyor with all sident #72 since their not include the surveyor with all sident #72 since their not include the 5.4b1 incident on PM, the surveyor interviewed tated their room was after an incident with with their NP and Resident conversation and Resident at 9.4b1 Resident at 9.4b1 Resident the surveyor interviewed tated their not make after an incident with with their NP and Resident conversation and Resident at 9.4b1 Resident the surveyor interviewed tated their not mestident (at NJ Exec Order 26.4b1) Resident the survey and the survey and the survey and the survey at the	F	609	abuse/neglect/misappropriation origin reported timely. Results of the audits be reviewed Monthly with QAPI until substantial compliance is met. The Q. Committee consists of the NHA, DON Medical Director. 5. Date when corrective action will be completed: June 12, 2023.	will API ⊨and	

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/05/2024 MAPPROVED). 0938-0391
STATEMENT O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		315524	B. WING			06/0	01/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
LAUREL E	3ROOK REHABILITATIO	N AND HEALTHCARE CENTER	-	718 CHURCH ROAD	8054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From page check.	∋ 4	F 609				
	surveyor there was no The surveyor then as of an incident betwee that day, and the DOI informed the DON wh informed them, and the NJ Exec Order 26.4b1 unaware of the of the have been a Progress should have been sta NJ Exec Order 26.4b1	hat they were both were and well as Resident #146's The DON stated she was situation, but there should s Note and an investigation arted because it was 5.4b1					
	the Unit Manager/Lice (UM/LPN) who stated conducted by unit ma the DON for incidents NJ Exec Order 26 The sur about the incident tha the UM/LPN stated st meeting and when sh NP and multiple staff #146's room. The DO #146 requested WExec nothing of it because #72 complained about offered State Order 26.48 declined. The UM/LF and knew there was a there were at least ter the room at the time w CNAs, and housekee	anagers, supervisors, and that included allegations of 5.4b1 veyor asked the UM/LPN at occurred on """""""""""""""""""""""""""""""""""					

Facility ID: NJ03015

If continuation sheet Page 5 of 31

		ND HUMAN SERVICES				FORM	D: 06/05/2024 APPROVE
		MEDICAID SERVICES					0. 0938-039 ⁻
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				LETED
		315524	B. WING				C 101/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	01/2025
					18 CHURCH ROAD		
LAUREL E	BROOK REHABILITATIO	N AND HEALTHCARE CENTER			OUNT LAUREL, NJ 08054		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	•	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
F 609	Continued From page	o 5		c00			
1 009	Continued From page	e o ent and there should have		609			
		as well as an investigation.					
		AM, the surveyor interviewed the facility investigated all					
	allegations o NJ Ex						
		The DON					
		of WExec Orde were reported to					
		tely, investigated, and then a					
	-	ted. The DON confirmed it					
	was not investigated	or reported.					
	On 6/1/23 at 9:56 AM	1, the LNHA in the presence					
	of the DON, Regiona	I Director of Clinical					
		vey team acknowledged that					
	the incident was not to surveyor inquiry.	reported to the NJDOH prior					
	A review of the facility	y's "Abuse, Neglect, propriation - Reporting and					
		dated revised September					
		ports of resident abuse					
		unknown origin), neglect,					
		misappropriation of resident					
	property are reported agencies (as required	l to local, state and federal					
	thoroughly investigat						
		dministrator or the individual					
	making the allegation	n immediately reports his or					
	her suspicion to the f	÷ ·					
		censing/certification agency					
	responsible for surve	ying/licensing the " is defined as within two					
		n involving abuse or result in					
	serious bodily injury.	-					
	NJAC 8:39-9.4(f)						
F 610 SS=D	Investigate/Prevent/0	Correct Alleged Violation	F	610			6/12/23
RM CMS-256	37(02-99) Previous Versions Ob	solete Event ID: X61	G11	Faci	ility ID: NJ03015 If cont	inuation she	et Page 6 of

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 06/05/2024 RM APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		E SURVEY IPLETED
		315524	B. WING			0	C 6/01/2023
NAME OF PF	ROVIDER OR SUPPLIER	l		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL E	ROOK REHABILITATIO	N AND HEALTHCARE CENTER			718 CHURCH ROAD		
				N	MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	Continued From page CFR(s): 483.12(c)(2)		F	610			
		se to allegations of abuse, or mistreatment, the facility					
	§483.12(c)(2) Have e violations are thoroug	vidence that all alleged hly investigated.					
		t further potential abuse, or mistreatment while the gress.					
	designated represent accordance with Stat Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by:	the results of all administrator or his or her ative and to other officials in e law, including to the State n 5 working days of the eged violation is verified e action must be taken. is not met as evidenced n, interview, and review of			F610 Investigate/Prevent/Correct All	eged	
	pertinent facility docu that the facility failed of NJ Exec Order #72 and #146 on NEW a resident sent to the a NJ Exec Order on NEW Cord. This defic for 2 of 3 residents re	ments, it was determined to investigate a.) an incident 26.4b1 for Resident ^{order 2} , and b.) an incident with emergency department with 26.4b1 ient practice was identified viewed for ^{W Exec Order26451} 2 and #189), and was			Violation CFR(s): 483.12(c)(2)-(4) 483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: 483.12 (2) Have evidence that all alleged violations are thoroughly investigated 483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation i progress. 483.12(c)(4) Report the response of all investigations to the administrat his or her designated representative a	of 2(c) s in ults or or	
		72 sitting in their room. In the surveyor that on			to other officials in accordance with S law, including to the State Survey Ag within 5 working days of the incident, if the alleged violation is verified	ency,	

Facility ID: NJ03015

If continuation sheet Page 7 of 31

ATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		NO. 0938-03 ATE SURVEY
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING) CO	OMPLETED
						С
		315524	B. WING			06/01/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD		
				MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE
F 610	Continued From page	e 7	F 610			
	NJ Exec Order 26			appropriate corrective action	must be	
		#146). Resident #72		taken.		
	reported that Resider	nt #146 was speaking with		1. All residents still reside in t		
		er (NP), and the NP asked		and both cases were fully inv	•	
		stion, which the resident did		Residents #72 and #146, the	-	
		e (Resident #72) answered		and Conclusion was submitte Department of Health on ^{WEXE}		
	Resident #1/6 becar	esident #72 continued that ne ^{WEXCOR} that he/she was		Resident #189 still resides in	the facility	
	speaking on their beh			the case was fully investigate		
	NJ Exec Order 26			resident is currently at baselin		
		Resident's #72 stated		2. All cases of residents with		
	multiple staff were inv	volved to ^{NJ Exec Order 26.4b1} ,		of abuse, neglect or misappro		
		ng Aide (CNA) ^{NJ Exec Order 26.4b1}		have the potential to be affect		
		nd stated the CNA stated		deficient practice. The NHA a		
		coming. Resident #72		cases of residents with allega		
	reported that Resider	it #146 was moved that day.		abuse, neglect, or misapprop assure that identified cases w		
	The surveyor reviewe	ed the medical record for		investigated timely.	ere	
	Resident #72.			3. The DON/designee re-edu	cated the	
				interdisciplinary team and all		
	A review of the Admis	sion Record face sheet (an		on the investigation for Abuse		
	admission summary)	reflected the resident was		Exploitation or Misappropriati	on.	
	admitted to the facility	/ in ^{NJ Exec Order 26.4b1} , with		4. The NHA/designee will aud		
	diagnoses which inclu	uded NJ Exec Order 26.461		reports, grievances and hosp	italizations to	
				ensure all allegations of abuse/neglect/misappropriation		
				investigated, daily X5 weekly		
	A review of the most	recent quarterly Minimum		monthly x3. Results of the au		
	Data Set (MDS), an a			reviewed Monthly with QAPI		
		rief interview for mental		substantial compliance is met		
	status (BIMS) score c	of ^{NJ Exe} out of 15, which		Committee consists of the NH	IA, DON and	
	indicated a NJ Exec Or	der 26.4b1		Medical Director.		
	A maximum of the - Dr			5. Date when corrective actio	n will be	
	A review of the Progre the incident from	ess Notes did not include		completed: June 12, 2023.		
	The surveyor reviewe	ed the medical record for				
	,					

Facility ID: NJ03015

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DEPART CENTER	FORM	APPROVED 0.0938-0391						
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		E CONSTRUCTION	(X3) DATE COMP		
		315524	B. WING			06/01/2023		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
LAUREL I	BROOK REHABILITATIO	N AND HEALTHCARE CENTER			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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 610	A review of the Admis reflected the resident in ^{NJ Exec Order 264b1} , with o NJ Exec Order 264b1, with o A review of the admiss reflected a BIMS score indicated a NJ Exec Or A review of the Progra the incident from N Exec Order 264 On 5/23/23 at 10:49 <i>A</i> Home Administrator (Nursing (DON) provide investigations for Res admission. This did r NJ Exec Order 264 N Exec Order 264 On 5/23/23 at 12:32 F Resident #146 who st changed or N Exec Order 264 N	sion Record face sheet was admitted to the facility diagnoses which included 0.4b1 sion MDS dated 1. sion MDS dated 1. ess Notes did not include 1. ass Notes did not include 1. ass Notes did not include 1. ass Notes did not include 1. ass Notes did not include 1. bident #72 since their not include the 1. ass Notes did not include 1. bident #72 since their not include the 1. ass Notes did not include 1. bident #72 since their not include the 1. bident WIT 1. ass Notes did not include 1. bident #72 since their not include the 1. conversation and Resident 1. conversation and Resident 1. conversatio	F	610				

Facility ID: NJ03015

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/05/2024 APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				SURVEY PLETED
		315524	B. WING				01/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL E	3ROOK REHABILITATION	N AND HEALTHCARE CENTER			718 CHURCH ROAD NOUNT 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page	e 9 he <mark>NJ Exec Order 26.4b1</mark> .	F	610			
	DON if the facility inve occurred on ^{NJ ExecOrder2®} b	M, the surveyor asked the estigated the incident that between Resident #72 and tated she would have to					
	surveyor there was no The surveyor then asl of an incident betwee that day, and the DON informed the DON wh informed them, and the N Exec Order 26.4b1 J Exec Order 26.4b1	nat they were both the and well as Resident #146's The DON stated she was situation, but there should s Note and an investigation rted because it was					
	the Unit Manager/Lice (UM/LPN) who stated conducted by unit ma the DON for incidents NJ Exec Order 26 The sum about the incident tha the UM/LPN stated sh meeting and when sh NP and multiple staff #146's room. The DO #146 requested a ^{N Exe} nothing of it because #72 complained about offered ^{N Exec Order 26,450}	I investigations were inagers, supervisors, and that included allegations of 5.4b1 veyor asked the UM/LPN at occurred on the UM/LPN and the was in a care conference the returned to the unit, the were in Resident #72 and DN stated that Resident or order 26.4b1, and she thought a few weeks ago Resident it NJ Exec Order 26.4b1 and was					

Facility ID: NJ03015

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF		
		315524	B. WING			06/01/2023		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL		N AND HEALTHCARE CENTER			718 CHURCH ROAD IOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 610	and knew there was a there were at least te the room at the time were CNAs, and housekee confirmed there was a Note about the incide been documentation On 5/24/23 at 11:58 A the DON who stated the allegations o NJ Exe stated that initially it were NJ Exec Order 20 until surveyor inquiry have been investigate DON if the UM/LPN s members present in a possibly happened the and the DON confirm On 6/1/23 at 9:56 AM of the DON, Regional Services, and the sur- the incident was not i been until surveyor in staff involved were ex- this incident.	The UM/LPN stated The UM/LPN stated n staff members present in which included the NP, ping staff. The UM/LPN no documented Progress nt and there should have as well as an investigation. AM, the surveyor interviewed the facility investigated all C Order 26.4b1 The DON vas reported that the 6.4b1 , and it was not did they realize it should ed. The surveyor asked the stated there was ten staff a room, that something at should be investigated, ed it should have been. I, the LNHA in the presence I Director of Clinical vey team acknowledged that nvestigated and should have inquiry. The LNHA stated all	F	610				

If continuation sheet Page 11 of 31

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 06/05/2024 RM APPROVED O. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		315524	B. WING		0	C 6/01/2023
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
LAUREL B	ROOK REHABILITATION	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN ((X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	COMPLETION DATE
F 610	Continued From page	9 11	F 610			
	A review of the Admis	sion Record face sheet				
		dent was admitted to the				
	of ^{NJ Exec Order 26.4b1} , with	6.4b1 with a readmission date n diagnoses which included				
	NJ Exec Order 26	6.4b1				
		recent quarterly MDS dated				
		IMS score of ^{Met} out of 15, Exec Order 26.4b1				
	Further review reveal	ed that the resident required				
	for Activities of Daily I assistance with one p	Living (ADLS) extensive				
		and was				
	frequently NJ Exec Or	der 26.401				
	A review of the Progre	ess Notes (PN) reflected a				
		ated WExecorder at 4:47 AM, that itted to the hospital with a				
	diagnosis of <mark>NJ Exe</mark>					
		/isit Summary (discharge				
	;	hospital with a printed date summary of the hospital				
	course reflected that t	the resident was in the				
	hospital for ^{NJ Exec Order} have ^{NJ Exec Order 26.4b1} .	^{26.4b1} and was found to The resident had a				
	NJ Exec Order 26					
		was seen by a 1 and had a ^{NJ Exec Order 26.4b1}				
	NO EXEC Order 20.40					

Event ID: X61G11

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	
		315524	B. WING				01/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL I	BROOK REHABILITATIO	N AND HEALTHCARE CENTER			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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 610	NJ Exec Order 26 The NJ Exec Order 26 NJ Exec Order 28 The resident was sent to to (ED) for NJ Exec Order 28 in the ED, an had a NJ Exec Order 26 in the ED, an had a NJ Exec Order 26 On 5/23/23 at 12:43 F the Director of Nursin the resident had a NJ N Exec Order 20 On 5/23/23 at 12:43 F the Director of Nursin the resident had a NJ N Exec Order 20 On 5/24/23 at 10:12 A the Nurse Practitioner resident had NJ Exec Ord . The resident had NJ Exec Ord investigation. On 5/24/23 at 10:12 A the Nurse Practitioner resident had NJ Exec Ord . The resident had NJ Exec Ord	Ab1 resident was placed on an 4b1 and had marked 4b1 and had marked 4b1 after having a cluded a Nurse Practitioner at 6:37 PM, that the ing N Exec Order 26.4b1 that the he emergency department rder 26.4b1 performed at the hospital xec Order 26.4b1 esident was manually 3.4b1 d or N Exec Order 26.4b1 PM, the surveyor interviewed g (DON), who stated that tree order 26.4b1 PM, the surveyor interviewed g (DON), who stated that tree order 26.4b1 The DON further stated thave completed an AM, the surveyor interviewed r (NP) who stated that the	F	610			

If continuation sheet Page 13 of 31

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		315524	B. WING _				C 01/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LAUREL E	BROOK REHABILITATION	N AND HEALTHCARE CENTER			718 CHURCH ROAD IOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH (PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 610	he/she was sent to the that the there or or a factor is had On 5/24/23 at 11:45 A Resident #189 who st NJ Exec Order 26:451 and h and was sent to the E stated that they were NJ Exec Order 26:451 On 5/31/23 at 12:45 F the DON in the prese Home Administrator (the resident had NJ Exec completed an investig A review of the facility Incidents - Investigatii included all incidents residents, employees [etcetera], occurring of investigated and repo The nurse supervisor, department director o initiate and document accident or incident A review of the facility Exploitation or Misapp Investigating" policy of 2022, included all rep (including injuries of u exploitation, or theft/m	Proder 26.4b1 ad V Exec Order 26.4b1, so e ED. The NP further stated been performed in the ED. AM, the surveyor interviewed tated they had sudden ad V Exec Order 26.4b1 ad V Exec Order 26.4b1 at the facility ED. The resident further admitted to the hospital with PM, the surveyor interviewed nce of the Licensed Nursing LNHA). The DON confirmed Corder 26.4b1 and should have gation. r's undated "Accident and ng and Reporting" policy and accidents involving , visitors, vendors, on our premises shall be orted to the administrator. /charge nurse and/or r supervisor shall promptly investigation of the r's "Abuse, Neglect, propriation - Reporting and lated revised September orts of resident abuse unknown origin), neglect, nisappropriation of resident to local, state and federal	F	510			
	thoroughly investigate	ed by facility management. gations are documented and					

Facility ID: NJ03015

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
			A. DOILDING		с
		315524	B. WING		06/01/2023
IAME OF PF	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	
				3718 CHURCH ROAD	
AUREL E		N AND HEALTHCARE CENTER		MOUNT LAUREL, NJ 08054	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO
F 610	Continued From page	2 14	F 61	0	
		istrator or the individual	1.01		
	· ·	immediately reports his or			
	her suspicion to the fo				
		censing/certification agency			
	responsible for surve				
		is defined as within two			
	serious bodily injury	i involving abuse or result in			
	serious bouily injury.				
	NJAC 8:39-4.1(a)5; 2	7.1(a)			
F 658	Services Provided Me	eet Professional Standards	F 65	8	6/12/23
SS=D	CFR(s): 483.21(b)(3)	(i)			
	§483.21(b)(3) Compr	abanaiya Cara Plana			
		d or arranged by the facility,			
	-	mprehensive care plan,			
	must-				
	(i) Meet professional				
		is not met as evidenced			
	by:	.,			
		n, interview, and review of ments. it was determined		F658 Services Provided Meet Professional Standards	
	that the facility failed	,		Services Provided Meet Professional	
	-	g to physician's orders; b.)		Standards CFR(s): 483.21(b)(3)(i)	
		rder; and c.) contact the		483.21(b)(3) Comprehensive Care Pla	ans
		ian for a medication (vitamin		The services provided or arranged by	the
		le in accordance with		facility, as outlined by the comprehense	
		Is of practice. This deficient		care plan, must- (i) Meet professional	
	practice was identified	ion administration (Resident		standards of quality. 1. Residents # 282 were evaluated ar	hd
	#282), and was evide			had no ill effect from the deficient practice and the deficient practice an	
	,,			The resident was assessed, the physic	
		ey Statutes Annotated, Title		was notified, new orders received and	t l
	45, Chapter 11. Nursi			implemented. Resident was discharge	ed
		tate of New Jersey states:		on ^{NJ Exec Order 26.4b1}	
		ng as a licensed practical		2. All residents have the potential to b	
	nurse is defined as pe responsibilities within			affected by this deficient practice. DO audited all residents MARs/TARs to	

Facility ID: NJ03015

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		<u>O. 0938-03</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED
						С
		315524	B. WING		06	/01/2023
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
		N AND HEALTHCARE CENTER		3718 CHURCH ROAD		
		AND HEALTHCARE CENTER		MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 658	Continued From page	e 15	F 65	8		
		e patient and family teaching		identify any medications that we	re not	
	program through hea			available and to assure if medic		
		sion of supportive and		available in back up supply and		
	restorative care, und			was notified of any medications		
	-	censed or otherwise legally		available and if substitution was	•	
	authorized physician	or denust.		3. The Director of Nursing will re all nurses on the Unavailable M		
	1. On 5/18/23 at 8:10	AM, the surveyor observed		process, physician notification a		
		al Nurse (LPN) preparing to		required documentation.		
		ns to Resident #282. The		4. The DON/designee will audit	all	
	surveyor observed th	e LPN NJ Exec Order 26.4b1		Medication Administration Reco		
		into a		assure all medications are avail		
		at time, the surveyor asked Medication Administration		administration. Daily x5 weekly monthly X 3. Results of the aud		
		MAR reflected a physician's		reviewed Monthly with QAPI unt		
	order (PO) dated	^{Order 26} , for ^{NJ Exec Order 26.4b1}		substantial compliance is met. T		
	give	e one capsule by mouth one		Committee consists of the NHA,	DON and	
		The LPN and surveyor		Medical Director.		
				5. Date when corrective action v	vill be	
	which indicated each	knowledged that she should		completed: June 12, 2023.		
		hysician to clarify the above				
	order.					
	2 On that same date	and time, the LPN and				
		e MAR and observed a PO				
	dated ^{NJ Exec Order 26} , for N.	J Exec Order 26.4b1 by mouth				
	one time a day. The	LPN stated, "the medication				
		The surveyor asked the LPN				
	how long it had not b	een available. The LPN				
		been available for the past				
	-	as not able to administer it.				
	-	he LPN if she had contacted physician, and the LPN				
		N acknowledged she should				
		harmacy. At that time, the				
	LPN called the pharn	nacy who informed her the				
		ailable in ^{NJ Exec Order 26,451} . Further				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 06/05/2024 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		315524	B. WING					01/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL E	3ROOK REHABILITATION	N AND HEALTHCARE CENTER			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 TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 658	review of the MAR review of the medication had be and signed the MAR review have signed the MAR administered the med The LPN acknowledg contacted the pharma first identified the med The surveyor reviewe Resident #282. A review of the Admis admission summary) admitted to the facility diagnoses which inclu and NJ H A review of the admis (MDS), an assessment reflected that the reside mental status (BIMS) indicated an NJ Execord A review of the Order PO dated Mercord A review of the Order PO dated Mercord (ay, and a PO dated NJ Exec Order 26.4b1 A review of the Progree	vealed the LPN signed that een administered on Verecomment N stated she should not a indicating that she had dication when she had not. ued that she should have acy on Verecomment acy on Verecomment dication was not available. A the medical record for estion Record face sheet (an reflected the resident was y in Verecorder 26.4b1 Exec Order 26.4b1 estion Minimum Data Set int tool dated Verecomment dent had a brief interview for score of Verecorder 26.4b1 estion Action of 15, which er 26.4b1 Summary Report included a NJ Exec Order 26.4b1 basule by mouth one time a NJ Exec Order 26.4b1 basule by mout	F	658				

Event ID: X61G11

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STATEMENT OF GERGENCES AND RUN OF CORRECTION (XI) INDUCERSUMPLIENCY IDENTIFICATION NUMBER (XI) INDUCERSUMPLIENCY IDENTIFICATION NUMBER (XI) INDUCERSUMPLIENCY IDENTIFICATION NUMBER (XI) INDUCERSUMPLIENCY IDENTIFICATION EXCENTION IN INC. (XI) INDUCERSUMPLIENCY IDENTIFICATION EXCENTION INC. (XI) INDUCERSUMPLIENCY IDENTIFICATION INC. (XI) INDUCERSUMPLIENCY IDENTIFICATION IDENTIFICATION IDENTIFICATION INTO INFORMATION IDENTIFICATION IDENTIFICATION INFORMATION IDENTIFICATION INFORMATION IDENTIFICATION IDE		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/05/2024 APPROVED). 0938-0391	
315524 B. WNO Ode(01/2023) IMME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STME, ZP CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 6054 STREET ADDRESS, CITY, STME, ZP CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 6054 Street MOUNT LAU	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		_	(X3) DATE COMP	SURVEY LETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE_20F CODE LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER 378 CHURCH ROAD PAUR ISUMMARY STATEMENT OF DEFICIENCES 378 CHURCH ROAD PHETIX ISUMMARY STATEMENT OF DEFICIENCES D PHETIX ISOMMARY STATEMENT OF DEFICIENCES D PHETIX ISOMMARY STATEMENT OF DEFICIENCES PROVIDERS PHALE, JN 80864 On 5/31/23 at 91:2 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the LPN should have checked the physician's orders with the medication label prior to administering the medication as per the physician's orders. The DON stated that the LPN should have contacted the pharmacy on the first day that the LPN should have contacted the pharmacy on the first day that the LPN should have contacted the pharmacy on the first day that the LPN should have signed the MAR indicating she had administerator (LIMHA), DON, and administerator F 658 On 6/1/23 at 9:56 AM, the survey team met with the Licensed Nursing Home Administrator (LIMHA), DON, and administerator F On Acknowledged the LPN strough the MAR indicating she had administering the medication was not available to be administration. F A review of the facility's undated "Medication Administration (LIMHA), DON, and administering the medications was and administering the medications was achieved the Desideministering the medications was achieved the DNS or the streng administering the medications wascuri day is defined and administer the dose exacity as o			315524	B. WING					
MOUNT LAUREL, NJ 98054 PAUID PREFX TRG MOUNT LAUREL, NJ 98054 PAUD PREFX TRG PROVIDENCE: PREFX RESULTORY OR LS DENTIFYING INFORMATION DENTIFYING INFORMATION F 658 Continued From page 17 On 5/31/23 at 9:12 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the LPN should have checked the physician's order. The Don acknowledged that the LPN should have contacted the pharmacy on the first day that the medication asper the physician's order. Don acknowledged that the LPN should have contacted the pharmacy on the first day that the DON acknowledged that the LPN should have contacted the pharmacy on the first day that the DON acknowledged that the LPN should have contacted the pharmacy on the facility's undated "Medication diverse administrator (LNHA), DON, and Regional Director of Clinical Services to discuss the above concerns. The DON acknowledged the LPN's rooms and stated that the LPN should have signed the MAR indicating she had administrator (LNHA), DON, and Regional Director of Clinical Services to discuss the above concerns. The DON acknowledged the LPN's rooms and stated that the tPN should have signed the MAR indicating she had administrator (LNHA), DON, and Regional Director of Clinical Services to discuss the above concerns. The DON acknowledged the LPN's rooms and stated that the tPN should have signed the MAR indication section to check the medication container label with the MAR, administer the medications exactly as ordered and administers the dose exactly as ordered and administer the dose exactly as ordered and administers F 697 F 697 Pain Management CPR(s): 483.25(k) F 12/23	NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE			
Precisive Trice (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULTORY OR USE DENTFYING INFORMATION) PREFIX Tag Cach DEFICIENCY CATTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE Communication DEFICIENCY F 658 Continued From page 17 On 5/31/23 at 9:12 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the LPN should have checked the physician's orders with the medication as per the physician's orders. F 658 D nacknowledged that the LPN should have called the resident's primary care physician to clearify the order of the facility only had use not available. F 658 On 6/1/23 at 9:56 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and Regional Director of Clinical Services to discuss the above contraded the pharmacy on the first day that the medication sub and administering that uses not available to be administered. F 657 A review of the facility on administering the the LPN should have capsules and not have contacted the pharmacy on the first day that the effective to discuss the above contacted the pharmacy on the first day that the effective to discuss the above contacted the pharmacy on the first day that the effective to discuss the above contacted the pharmacy on the facility's undated "Medication Administered. F 667 A review of the facility's undated "Medication container label with the MAR, administer the dose exactly as ordered and administer F 667 F 612/23 <td>LAUREL E</td> <td>BROOK REHABILITATIO</td> <td>N AND HEALTHCARE CENTER</td> <td></td> <td></td> <td>08054</td> <td></td> <td></td>	LAUREL E	BROOK REHABILITATIO	N AND HEALTHCARE CENTER			08054			
On 5/31/23 at 9:12 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the LPN should have checked the physician's orders with the medication as per the physician's order. The DON acknowledged that the LPN should have called the resident's primary care physician to clarify the order if the facility only had the strategies of the LPN should have contacted the pharmacy on the first day that the LPN should have contacted the pharmacy on the first day that the LPN should have contacted the pharmacy on the first day that the LPN should have contacted the pharmacy on the first day that the LPN should have contacted the pharmacy on the first day that the LPN should have contacted the DON stated the LPN should have contacted the DON stated the LPN should have contacted the DON acknowledged the LPN's errors and stated that the LPN's errors and stated that the the administering the medications was not available to be administred.A review of the facility's undated "Medication (LNHA), DON, and Regional Director of Clinical Services to discuss the above concerns. The DON acknowledged the LPN's errors and stated that the LPN should have signed the MAR indicating she had administering the medications was to check the medication Container label with the MAR, administerion the medications exactly as ordered an administer the dose exactly as ordered and administer the dose exactly as ordered.F 6976/12/23	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORR	ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA		COMPLETION	
F 697 Pain Management F 697 6/12/23 SS=D CFR(s): 483.25(k) 6/12/23	F 658	On 5/31/23 at 9:12 Al the Director of Nursin LPN should have che with the medication la the Medication as per DON acknowledged t called the resident's p clarify the order if the Capsules and DON stated the LPN pharmacy on the first was not available. On 6/1/23 at 9:56 AM the Licensed Nursing (LNHA), DON, and Re Services to discuss th DON acknowledged t that the LPN should r indicating she had ad (Medications) that was r administered. A review of the facility Administration Obser includedthe nurse a medications was to cl container label with th medications exactly a	M, the surveyor interviewed g (DON) who stated that the ecked the physician's orders abel prior to administering ure she was administering the physician's order. The hat the LPN should have orimary care physician to facility only had surveyor correction d not should have contacted the day that the SUEXCORE 26:401 A, the survey team met with Home Administrator egional Director of Clinical he above concerns. The he LPN's errors and stated not have signed the MAR ministered a medication hot available to be r's undated "Medication vation Worksheet" policy doministering the heck the medication he MAR, administer the as ordered and administer	F 6	58				
§483.25(K) Pain Management.		Pain Management CFR(s): 483.25(k)		F 6	97			6/12/23	
		∣ §483.25(k) Pain Mana	agement.						

Facility ID: NJ03015

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						NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		ATE SURVEY MPLETED
						С
		315524	B. WING			06/01/2023
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		CODE	
LAUREL E	ROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD		
				MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 697	Continued From page	e 18	F 69	97		
		ure that pain management is				
	-	who require such services,				
		ssional standards of practice,				
	and the residents' go	erson-centered care plan,				
	-	Γ is not met as evidenced				
	by:					
	Complaint NJ #1601	50		F697 Pain Management C	CFR(s):	
	Based on interview	closed medical records, and		483.25(k) 483.25(k) Pain Manageme	ont. The facility	
		icility documents, it was		must ensure that pain mar		
	determined the facilit	y failed to a.) assess and		provided to residents who		
		nt's WExec Order 26.40; b.) document		services, consistent with p		
	the administration of	an as needed e-evaluate and document the		standards of practice, the of person-centered care plan		
	effectiveness of NJ Exe	ec Order 26.4b1 in accordance		residents' goals and prefer		
		ndards of practice. This		1. Resident #435 no longe		
		s identified 1 of 3 residents		facility.		
		Order 26.4b1 (Resident #435),		2. All residents have the po		
	and was evidenced b	by the following:		affected by this deficient pl audited all residents MARs		
				ensure that residents with		
	On 5/17/23 at 11:35	AM, the surveyor reviewed		assessed, pain level was o	•	
		ecord for Resident #435.		pain medication was admin		
	A			documented, and resident		
		ssion Record face sheet (an reflected the resident was		reassessed for effectivene documented.	ss and	
		y in ^{NJ Exec Order 26.4b1} , with		3. The Director of Nursing	re-educated all	
		uded NJ Exec Order 26.4b1		nurses on pain assessmer		
				documentation, pain medic		
				administration and docume		
				resident's pain reassessed effectiveness and docume		
				4. The DON/designee will		
				Medication Administration,		
				x4 and monthly X 3. Resu		
				will be reviewed Monthly w		
	A review of the admis			substantial compliance is r	net. The QAPI	

Event ID: X61G11

Facility ID: NJ03015

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CORRECTION			PLE CONSTRUCTION	· · · ·	E SURVEY
	IDENTIFICATION NUMBER:	A. BUILDING	G	COM	PLETED
	315524	B. WING			С
OVIDER OR SUPPLIER	515524		STREET ADDRESS, CITY, STATE, ZIP CODE	06	6/01/2023
			3718 CHURCH ROAD		
ROOK REHABILITATIO	N AND HEALTHCARE CENTER		MOUNT LAUREL, NJ 08054		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETIO DATE
(MDS), an assessme reflected the resident mental status (BIMS) indicated a N Exec O indicated the resident N Exec Order 26.4b1 and in the las N Exec Order 26.4b1 and N Exec Order 26.4b1 and N Exec Order 26.4b1 and N Exec Order 26.4b1 and	nt tool dated "Execoder 20"; had a brief interview for score field out of 15, which der 26.4b1. A further review t received routine scheduled as needed "Exect at five days with frequent Order 26.4b1 with an ec Order 26.4b1 dualized comprehensive care a focus area dated "Execoder"; Order 26.4b1 herventions included to Order 26.4b1 (Source 26.4b1) (Source 26.4b1) (S	F 65	Medical Director.	<i>v</i> ill be	
	SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page (MDS), an assessme reflected the resident mental status (BIMS) indicated a NJ Exec O indicated the resident NJ Exec Order 26.4b1 and in the las NECCO INFORMATION A review of the individ plan (ICCP) included for I have NJ Exec as per orders, observ signs and symptoms need for NJ Exec as per orders, observ intervert administer NJ Exec as per orders, observ intervert as applicable; evalua interver the presence of NJ Exec I A further review of the area dated NJ Exec I A further review of the area dated NJ Exec I A further review of the A further review of the Order A further 26.4b1 , have	A further review of the ICCP included a focus area dated ^{11 Execontere} , for I am on ^{10 Exec Order 26.4b1 . Interventions included to administer medication as ordered and monitor for effectiveness and adverse effects; monitor for NJ Exec Order 26.4b1 observe for adverse reactions with every interaction with the resident; monitor safety due to potential increased risk for ^{10 Exec}; and NJ Exec Order 26.4b1 can rapidly reverse ^{NJ Exec Order 26.4b1}, have available in case of}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 19 (MDS), an assessment tool dated interflocted the resident had a brief interview for mental status (BIMS) score indicated a IV Exec Order 26.4b1. A further review indicated the resident received routine scheduled Viewe Order 26.4b1 and as needed in the last five days with frequent in the last five days with frequent in the last five days with frequent in the last five days with frequent intensity from NJ Exec Order 26.4b1 (ICCP) included a focus area dated interventions included to administer NJ Exec Order 26.4b1 (Interventions included to administer NJ Exec Order 26.4b1 (Interventions included to administer NJ Exec Order 26.4b1 (Interventions for Interventions for Interventions for Interventions for Interventions as applicable; evaluate effectiveness and signs and symptoms of side effects; anticipate my need for interventions; monitor and record the presence of every shift and as needed. A further review of the ICCP included a focus area dated interventions included to administer medication as ordered and monitor for effectiveness and adverse effects; monitor for NJ Exec Order 26.4b1 (Interventions included to administer medication as ordered and monitor for effectiveness and adverse effects; monitor for NJ Exec Order 26.4b1 (Interventions included to administer medication as ordered and monitor for effectiveness and adverse effects; monitor safety due to potential increased risk for in an and NJ Exec Order 26.4b1 (Intervention included in case of emergency. A review of the Order Summary Report with a Intervent of the order Summary Report with a	MOUNT LAUREL, NJ 08054 Isummary STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLANGE CORRECTIVE AP CROSS-REFERENCE OF THE AP DEFICIENCY) Continued From page 19 (MDS), an assessment tool dated indicated at the resident had a brief interview for mental status (BIMS) score Toutine scheduled indicated at the resident received routine scheduled in the last five days with frequent that last the vage offer 26.4b1 F 697 Medical Director. 5. Date when corrective action v completed: June 12, 2023. Some the vage offer completed: June 12, 2023. A review of the individualized comprehensive care plan (ICCP) included a focus area dated intensity from NJ Exec Order 26.4b1 Medical Director. A review of the individualized comprehensive care plan (ICCP) included a focus area dated interventions included to administer NJ Exec Order 26.4b1 A review of the ICCP included a focus area dated interventions included to administer were word the ICCP included a focus area dated interventions included to administer medication as ordered and monitor for NJ Exec Order 26.4b1 intervention includes in case of emergency. NJ Exec Order 26.4b1 intervention	UNUMEL, NJ 08054 Image: Construction of the proceeded synull, exception of the proceeded synull and exception of the proceeded synull, exception of the proceeded synull and exception of the proceeded synull, exception of the proceeded synull (CCP) included a focus are dated synull (CCP) included a focus are dated synull (CCP) included a focus area dated (CCP) (CCP) (CCP) (CCP) (CC

Facility ID: NJ03015

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		ID HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 06/05/2024 RM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		315524	B. WING		0	C 6/01/2023
NAME OF P	ROVIDER OR SUPPLIER		- <u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		
LAUREL	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 697	following physician's A PO dated ^{W Exec Order 24} , NJ Exec Order 26.4b1 A PO dated ^{W Exec Order 24} medication; give ^{W Exec Order 24} hours as needed for A PO dated ^{W Exec Order 24} tablet; give one tablet for NJ Exec Order 2 A review of the NJ Exec Administration Record	to WExec Order 26.4b1 every shift) every shift for WExec U Exec Order 26.4b1 every shift) every shift for WExec U Exec Order 26.4b1 tablet, an WExec order 26.4b1 of WExec Order U Exec Order 26.4b1 of WExec Order U Exec Order 26.4b1 t every four hours as needed 6.4b1. Order 26.4b1 Medication d (MAR) reflected on had a documented WExec	F 6		,	
	(3:00 PM to 11:00 PM corresponding admin N Exec Order 20:401 aNJ Exec Order 20:401 than no documentation that administered per PO N Exec Order 20:401 where the nu for that shift. A review of the Progr Practitioner Note date the resident was administered for the hospital NJ Exec O	during the day shift on rse documented a Maximore and a state of the s				

Facility ID: NJ03015

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	MENT OF HEALTH AN	D HUMAN SERVICES					FORM	D: 06/05/2024 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315524	B. WING					C 01/2023
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STAT	E, ZIP CODE		
LAUREL I	BROOK REHABILITATIO	NAND HEALTHCARE CENTER			718 CHURCH ROAD IOUNT LAUREL, NJ 080	54		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 697	had not received med documented Nurse's resident's Merce from the Director of N medications in their b On 5/18/23 at 7:50 Al Home Administrator (surveyor with the faci supply list which inclu On 5/18/23 at 8:56 Al the resident's License from Merce Order 26:49 nurse who worked bo shifts on Merce Order 26:49 facility and he/she was in a Merce Order 26:49 facility and he/she the initial PO for Merce number" Merce Order 26:49 and the pharmacy has medication and that d back-up system, so si Practitioner (NP) who continued that the resi that she recalled two back-up medication s Merce Order 26:49 and the pharmacy has medication s S Practitioner (NP) who continued that the resi that she recalled two back-up medication s Merce Order 26:49 and the pharmacy has medication and that db back-up system, so si Practitioner (NP) who continued that the resi that she recalled two back-up medication s Merce Order 26:49 administered to the resi	Add and VEXCORDER 284401 and ications yet. There were no Notes at this time for the M, the surveyor requested ursing (DON) a list of all ack-up supply system. M, the Licensed Nursing LNHA) provided the lity's back-up medication ded NEXCORDER 26.401 M, the surveyor interviewed ded NEXCORDER 26.401 M, the surveyor interviewed ded Practical Nurse (LPN) ted she was an Agency staff th the day and evening e LPN stated Resident #435 prior to admission to the solution of the livered the osage was not in the he had spoken to the Nurse changed the PO. The LPN ident received NEXCORDER 26.401, facility nurses accessed the ystem for her to obtain the stated the resident always Drder 26.401, and the resident e for their medication and stated NEXCORDER 26.401 was	F	697				

Facility ID: NJ03015

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/05/2024 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		315524	B. WING		_	06/0	; 01/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
LAUREL	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		718 CHURCH ROAD	8054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	the medication was n a Progress Note. The have documented on received from the back was no delay in the re- was no delay in the re- verse order code On 5/18/23 at 9:30 AI from the LNHA all the for Resident #435's On 5/18/23 at 12:00 F declining inventory sh had not received the tablets until surveyor requested a NECCOMMENSION system for the resider On 5/22/23 at 11:43 A nurse removed NJ Ex- equal NECCOMMENSION PM, and she removed NJ Execommension at 9:30 PM or continued the LPN sig NECCOMMENSION and the number of tal same as the PO, as lo correct without obtain the physician.	Present on the MAR, lication, and then stiveness in a follow-up. If ot effective, the nurse wrote a LPN stated she must not the MAR the NEECOORDECONSTRUCT Present of the MAR the State of the must not the MAR the State of the must not the MAR the State of the state of the state of the must not the MAR the State of th	F 697				

Facility ID: NJ03015

If continuation sheet Page 23 of 31

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	
		315524	B. WING _				/01/2023
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL		N AND HEALTHCARE CENTER			18 CHURCH ROAD DUNT LAUREL, NJ 08054		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 697	PM, the DON stated to administering W Exector first completed a NJ E then administered me and the correspondence continued the nurse to assess the effective of and documented that confirmed there should for the W Exector of additional for the W Exector of additional additional there should for the W Exector of additional additional there is a discontinued administration, and the medication. The DOI speak to the effective because there was not on 5/23/23 at 10:51 A via telephone the resist resident was admitted and the stated the resident was hospital's recommend the resident complain reported relief with the the surveyor asked in resident did not recein NP stated when the re- facility, the facility had dosage since it w system, so she change tablets to obtain from On 6/1/23 at 9:56 AM of the LNHA, Regional	the process for Dider 26.4b1 was the nurse Exec Order 26.4b1, and edications based on the interventions of the medication based the interventions and the interventions and the interventions and the interventions based the interventions and the surveyor interviewed ident's NP who stated the d to the facility after a intervention of interventions and the facility after a intervention of interventions and the difficulty obtaining the intervention of interventions in their back-up ged the order to interventions and the back-up system. I, the DON in the presence	F	697			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/05/2024 FORM APPROVED OMB NO. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315524	B. WING		C 06/01/2023	
	ROVIDER OR SUPPLIER BROOK REHABILITATIO	N AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3718 CHURCH ROAD MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		
F 697 F 759 SS=D	being administered a documentation to det was effect A review of the facility Assessment and Mar includedimplementi strategiesimplement regimen as ordered, r results of the interver modifying approache pain and consequence for acute pain or sign chronic paindocum resident's reported le detail enough informa pain and the effective pain as necessary an pain management pro-	was not documented as nd there was no follow-up ermine if the tive. y's undated "Pain hagement" policy ng pain management at the pain medication carefully documenting the ntionsmonitoring and s: re-assess the resident's tess of pain at least each shift ificant changes in level of entation: document the vel of pain with adequate ation to gauge the status of eness of interventions for d in accordance with the	F 697		6/12/23	
	§483.45(f) Medication The facility must ensu §483.45(f)(1) Medica percent or greater;					
	This REQUIREMENT by: Based on observatio pertinent facility docu that the facility failed were administered wi more. During the me	is not met as evidenced n, interview, and review of ments, it was determined to ensure all medications thout an error of 5% or dication observation on observed three (3) nurses		F759 Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) 483.45(f) Medication Errors. The facility must ensure that its483.45(f)(1) Medication error rates are not 5 percer greater;		

Event ID: X61G11

Facility ID: NJ03015

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) D	NO. 0938-03 ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	C	OMPLETED
		315524	B. WING			С
	ROVIDER OR SUPPLIER	515524		STREET ADDRESS, CITY, STATE, Z		06/01/2023
	CONDER OR SOFFLIER			3718 CHURCH ROAD		
LAUREL E	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 759	Continued From page	25	F 75	50		
1 700		ns to three (3) residents.		1. Residents # 282 was	not affected by	
		tunities, and two (2) errors		the deficient practice. R	•	
		calculated a medication		assessed, physician wa		
		ate of 6.6%. This deficient		orders received and imp	plemented.	
	-	d for one (1) of three (3)		Resident was discharge	ed to home on	
		282) that were administered		NJ Exec Order 26.4b1. The LPN		
		1) of three (3) nurses. The s evidenced as follows:		re-educated on the 5 rig		
				Competency was comp		
	On 5/18/23 at 8:10 Al	M, the surveyor observed		2. All residents have the		
		al Nurse (LPN) preparing to		affected by this practice		
		o (22) oral medications to		3. The Director of Nursi	-	
	NJ Exec Order 26	included three (3) tablets of		nurses on the 5 Rights of administration.	of medication	
		blet of NJ Exec Order 26.4b1		4. The DON/designee w	/ill complete	
				Medication Administration	•	
				observation daily x5 we	•	
		me time, the surveyor		monthly X 3. Results of		
		ter Resident #282's room to		reviewed Monthly with (
		ations. The surveyor asked nedications and to step		substantial compliance Committee consists of t		
	outside the room.			Medical Director.		
				5. Date when corrective	action will be	
	Upon returning to the			completed: June 12, 20	23.	
	•	e Medication Administration				
		ne LPN. The MAR revealed PO) for <mark>NJ Exec Order 26.4b1</mark>				
		ablets by mouth one time a				
		Exec Order 26.4b1; give				
	one (1) tablet by mou	th one time daily. The LPN				
	stated that she thoug					
		er was the correct dosage				
	there were two different	t she did not realize that				
		The surveyor with the LPN,				
		over the counter (OTC)				
	house stock medicati	ons which included a bottle				
	labeled <mark>NJ Exec Order 2</mark> confirmed she did not	26.4b1 tablets. The LPN				
	والمستعد المتناط والمتعاد والمستقد والمستعد والمستعد والمستعد والمستعد والمستعد والمستعد والمستعد والمستعد والم	tablets in the	1	1		1

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/05/2024 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315524	B. WING		_		C 01/2023
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
LAUREL	BROOK REHABILITATION	AND HEALTHCARE CENTER		718 CHURCH ROAD	8054		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 759	the OTC house stock bottle labeled NJ Exe a bottle labeled NJ Exe a bottle labeled NJ Exe LPN stated that she d medications were not #2) The surveyor reviewe Resident #282. A review of the Admis admission summary) admitted to the facility diagnoses which inclu and NJ A review of the admis (MDS), an assessmen reflected that the resid mental status (BIMS) indicated an NJ Exec Order PO dated Merce and a PO dated for give three (3) tablets and a PO dated Merce is give three (3) tablets and a PO dated Merce is give three (3) tablets and a PO dated Merce is give three the precision is give three the precision the precision is give three the precision the precision is give the precision to entitle the medication to entitle with the medications to entitle the precision of the precision the precision of the precisio	audd have called the a order. Further review of medications revealed a ac Order 26.4b1 and ac Order 26.4b1 and ac Order 26.4b1 id not realize the two the same. (ERROR#1 & d the medical record for sion Record face sheet (an reflected the resident was in N Exec Order 26.4b1 Exec Order 26.4b1 sion Minimum Data Set ht tool dated N Exec Order 26.4b1 score of M out of 15, which er 26.4b1 Summary Report included a N Exec Order 26.4b1 tablet; oy mouth one (1) time a day for M out of 15, which and the surveyor interviewed g (DON) who stated that the cked the physician's orders bel prior to administering	F 759				

Facility ID: NJ03015

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
		315524	B. WING				C 101/2023
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL E	BROOK REHABILITATION	NAND HEALTHCARE CENTER			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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 759 F 761 SS=D	the Licensed Nursing (LNHA), DON, and Re Services to discuss th DON acknowledged t that the LPN was a ne re-educated on the fa administration of med A review of the facility Administration Observ- includedthe nurse a medications was to cf container label with th medications exactly a the dose exactly as of NJAC 8:39-11.2(b); 29 Label/Store Drugs an CFR(s): 483.45(g)(h)(§483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the e applicable. §483.45(h) Storage of §483.45(h)(1) In accor Federal laws, the faci biologicals in locked of temperature controls, personnel to have accor §483.45(h)(2) The face	Home Administrator egional Director of Clinical he above concerns. The he LPN's errors and stated ew nurse and would be cility's policy for the ications. 's undated "Medication vation Worksheet" policy dministering the neck the medication he MAR, administer the s ordered and administer rdered 9.2(d) d Biologicals (1)(2) of Drugs and Biologicals used in the facility must be e with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals rdance with State and lity must store all drugs and compartments under proper and permit only authorized		759			6/12/23

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		ND HUMAN SERVICES MEDICAID SERVICES				RM APPROVE 10. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
		315524			0	C 6/01/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				3718 CHURCH ROAD		
LAUREL		N AND HEALTHCARE CENTER		MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 761	Continued From page		F 76	1		
	the Comprehensive I Control Act of 1976 a abuse, except when t package drug distribu quantity stored is min be readily detected. This REQUIREMENT by: Based on observatio pertinent facility docu the facility failed to a. storage rooms free of (Jevity 1.5 calorie) for rooms inspected (Nor required Federal narco 222 form) were comp enable accurate reco	drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the simal and a missing dose can T is not met as evidenced on, interview, and review of ments, it was determined) maintain medication f expired nutritional formula r 1 of 3 medication storage rth 1), and b.) ensure the cotic acquisition forms (DEA oleted with sufficient detail to nciliation for 2 of 8 forms ent practice was evidenced		F761 Label/Store Drugs and Bic CFR(s): 483.45(g)(h)(1)(2) 483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals the facility must be labeled in acc with currently accepted profession principles, and include the appro accessory and cautionary instruct and the expiration date when app 483.45(h) Storage of Drugs and	s used in cordance nal priate tions,	
	Unit Manager/License (UM/LPN), the survey and medications in N The surveyor observe eight-ounce (8 oz) ca with the expiration da UM/LPN confirmed th and should not be in confirmed there were received Jevity 1.5 ca who had the respons dates in the medicate stated Central Supply (RD), and the unit ma	yor inspected the inventory orth 1 Medication Room. ed twenty-three (23) intons of Jevity 1.5 calorie the of 4/1/23. At this time, the mat the formula was expired active supply. The UM/LPN e no residents who currently alorie formula. When asked ibility for checking expiration on rooms, the UM/LPN y, the Registered Dietitian		 Biologicals 483.45(h)(1) In accordance with Federal laws, the facility must sto drugs and biologicals in locked compartments under proper tem controls and permit only authoriz personnel to have access to the 483.45(h)(2) The facility must pro- separately locked, permanently a compartments for storage of con drugs listed in Schedule II of the Comprehensive Drug Abuse Pre- and Control Act of 1976 and other subject to abuse, except when the uses single unit package drug di- systems in which the quantity sto minimal and a missing dose can readily detected. Jevity Supplement that was en- was removed and properly disca 	ore all perature ed keys. ovide affixed trolled vention er drugs e facility stribution ored is be	

Facility ID: NJ03015

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NC	0.0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		PLETED
		315524	B. WING		C 06/01/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL I	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE
F 761	 (DON), in the present Home Administrator (Clinical Services, Reg Operations, and surve Supply as well as the responsibility of check medication rooms. T the Jevity 1.5 calorie have been pulled from thirty days of the expiration available in the medice A review of facility's u Medications" policy in staff is responsible for storage and preparat and sanitary manner; or deteriorated drugs to the dispensing phat A review of the facility Responsibilities" includevelopment, mainter updating of the writter for the administration medications and supp 2. On 5/26/23 at 10:3 presence of the Direct reviewed eight DEA 2 revealed the following 	cc of the Licensed Nursing LNHA), Regional Director of gional Director of ey team, stated that Central unit managers had the king expiration dates in the he DON acknowledged that nutritional formula should in the medication room within tration date, and not cation room for resident use. andated "Storage of neluded 3. The nursing r maintaining medication ion areas in a clean, safe, 4. Discontinued, outdated, or biologicals are returned armacy or destroyed r's "Unit Manager Duties and uded participate in the nance, implementation and n policies and procedures , storage, and control of polies 5 AM, the surveyor in the etor of Nursing (DON) 222 forms provided which g: 21774084 dated 2/15/23,	F 761	May 31, 2023. DEA 222 Form sect was not completed by purchaser. Inventory sheets for order form nur 221774084 dated 2/15/23 and 221 dated 3/15/23 were obtained to ver receipt of narcotics issued on these 2. All residents have the potential t affected by this deficient practice. 3. DON/Designee will conduct an a all medication rooms and supply st areas to identify supplement expira dates on May 31, 2023. DON/Desig completed education on completion section 5 on the copy of DEA 222 f received by pharmacy, with Unit managers, Nursing supervisors, AI and License Nursing Staff. 4. DON/Designee will audit medica rooms and supply storage areas w 4, bi-weekly x 2, and monthly x 1 to ensure ongoing and sustained corr with this deficient practice. DON wil DEA 222 Forms section 5 for comp DON will audit weekly x 4, monthly ensure forms are in compliance will deficient practice. Findings will be reported monthly to the QAPI comm meeting until substantial compliance been met. The QAPI committee co of the DON, Administrator, and Me Director. 5. June 12, 2023	mber 774078 ify e dates. o be audit of orage ation gnee n of form, DON tion eekly x o ppliance ill audit pletion. x3 to th this mittee ce has onsists	

Facility ID: NJ03015

If continuation sheet Page 30 of 31

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/05/2024 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION			LETED
		315524	B. WING			_		C 01/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
LAUREL	BROOK REHABILITATIO	N AND HEALTHCARE CENTER			3718 CHURCH ROAD	8054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Order form number 2: Part 5: to be filled in the completed. A review of the instruct DEA 222 form located form included Part 5. Receipt 1. The purchatist its copy of the original of packages received each line item. At this time, the DON should have been continistructed. On 6/1/23 at 9:56 AM of the LNHA, Regional Services, and survey the DEA 222 forms for narcotics for the back since the deliveries at different hours, nursin medications. The DO receiving nurse should	21774078 dated 3/15/23, by Purchaser was not ctions for submission of the d on the reverse side of the Controlled Substance aser fills out this section on I form. 2. Enter the number and the date received for confirmed the two forms mpleted for Part 5 as , the DON in the presence al Director of Clinical team stated she completed or the ordering of the up medication system, but rrived to the facility at ng supervisors received the DN acknowledged the d have completed Part 5 on the time of receiving the	F	761				

Facility ID: NJ03015

If continuation sheet Page 31 of 31

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(3) DATE SURVEY COMPLETED
			A. BUILDING: _		C
		03015	B. WING	C 06/01/2023	
AME OF PF	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	TE, ZIP CODE	
AUREL E	ROOK REHABILITATIO	N AND HEALTHCAR	URCH ROAD		
		MOUNT	LAUREL, NJ 080	054	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
S 000	Initial Comments		S 000		
	standards in the New 8:39, standards for liv Facilities. The facility Correction, including deficieny and ensure implemented. Failure result in enforcement the provisions of the	to correct deficiencies may t action in accordance with New Jersey Administrative r 43E, enforcement of			
S 560	8:39-5.1(a) Mandator (a) The facility shall of Federal, State, and lo regulations.	comply with applicable	S 560		6/12/23
	by: Based on interview a documentation, it wa failed to maintain the care staff to resident State of New Jersey. of 42 shifts reviewed Findings include: Reference: New Jerse (NJDOH) memo, dat with N.J.S.A. (New J 30:13-18, new minim nursing homes," india	ey Department of Health ed 01/28/2021, "Compliance ersey Statutes Annotated) rum staffing requirements for cated the New Jersey		 S560- 8:39-5.1 (a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. 1.No residents were affected by not meeting the State of New Jersey minimus staffing requirements. 2.All residents could have the potential the affected by this area of concern. 3.Recruitment efforts continue to include A.Daily Staffing meetings B.Care Champion mentor program to support and retain staff 	d um o
	Governor signed into codified at N.J.S.A. 3	law P.L. 2020 c 112, 0:13-18 (the Act), which a staffing requirements in		C.Culture Committee to promote and improve staff morale D.Recruitment Bonuses, Sign on Bonus	es

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

TITLE

(X6) DATE

06/16/23

STATE FORM

Electronically Signed

X61G11

If continuation sheet 1 of 7

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					с	
		03015	B. WING		06/01/2023	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
AUREL B	BROOK REHABILITATIO	N AND HEALTHCAR	URCH ROAD LAUREL, NJ 08	054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE	
S 560	Continued From pag	e 1	S 560			
	nursing homes. The effective on 02/01/20 One Certified Nurse A residents for the day One direct care staff residents for the even fewer than half of all CNAs, and each dires signed in to work as nurse aide duties: an One direct care staff residents for the nigh direct care staff mem CNA and perform CN During entrance conf AM, the Licensed Nu (LNHA) in the preser (DON) stated that the average. The facility nurse managers to c utilized Agency staff. requested the facility Staffing Report" for the A review of the "Nurse by the facility for the and 5/7/23 to 5/13/23 to resident ratios that requirement of 1 CN/ shift as documented 4/30/23 had 19 CNAs shift, required 25 CN	following ratio(s) were 121: Aide (CNA) to every eight shift. member to every 10 ning shift, provided that no staff members shall be a CNA and shall perform ad member to every 14 at shift, provided that each aber shall sign in to work as a VA duties. Ference on 5/16/23 at 9:51 arsing Home Administrator nee of the Director of Nursing a facility's staffing was a had a call system to call ome in as needed, as well as At this time, the surveyor to complete the "Nurse he past two weeks. Se Staffing Report" completed weeks of 4/30/23 to 5/6/23 B, which revealed the staffing t did not meet the minimum A to 8 residents for the day below: s for 200 residents on the G CNAs. for 199 residents on the day		and Vacant Shift Bonuses offered E.Utilizing multiple outside staffing agencies to fulfill staffing needs F.Ongoing job fairs onsite G.On-demand orientation classes H.Prize raffles for staff picking up extra shifts I.Daily interviews being conducted with any walk ins 4.The Director of Nursing/Designee w monitor staffing daily x5, weekly x4, at monthly x3 to maintain ongoing staffin compliance. The Director of Nursing w report the results to the Quality Initiativ Committee. The Quality Initiative committee consists of the Administrato Director of Nursing, and the Medical Director. 5. Date when corrective action will be completed: June 12,2023	n Il nd g rill ve	

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		03015			06	C 06/01/2023
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	•	
	BROOK REHABILITATIO	N AND HEALTHCAP 3718 CH	URCH ROAD			
AUREL		MOUNT	LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
S 560	Continued From page	e 2	S 560			
	shift, required 25 CN/ 5/5/23 had 23 CNAs shift, required 24 CN/ 5/6/23 had 23 CNAs shift, required 24 CN/ 5/7/23 had 20 CNAs shift, required 24 CN/ 5/8/23 had 20 CNAs shift, required 24 CN/ 5/8/23 had 21 CNAs shift, required 23 CN/ 5/10/23 had 21 CNAs day shift, required 23 5/11/23 had 22 CNAs day shift, required 23 5/13/23 had 19 CNAs day shift, required 24 On 5/31/23 at 11:54 / the Staffing Coordinal responsibilities was to which included nurse Coordinator continue completed based on assigned CNA to eve shift; one CNA for eve evening shift; and on residents for the nigh bonuses, sent messa work another shift, ar cover callouts. The S	for 197 residents on the day As. for 195 residents on the day As. for 189 residents on the day As. for 189 residents on the day As. for 188 residents on the day As. for 188 residents on the day As. s for 188 residents on the CNAs. s for 188 residents on the CNAs. s for 194 residents on the CNAs. a for 194 residents on the CNAs. s for 194 residents on the CNAs.				

STATEMENT	ey Department of Hea T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X	3) DATE SURVEY COMPLETED	
		03015	B. WING		C 06/01/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
AUREL E	BROOK REHABILITATIO	N AND HEALTHCAR	URCH ROAD LAUREL, NJ 08	054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE	
S1405	Continued From page	e 3	S1405			
S1405	8:39-19.5(a) Mandato Sanitation	ory Infection Control and	S1405		6/12/23	
	physician assistant, w first day of employme the new employee re- assessment by a regi upon employment, th practice nurse's exan up to 30 days from th The facility shall esta	rse, or New Jersey licensed vithin two weeks prior to the ent or upon employment. If				
	by: Based on interview a documents, it was de failed to ensure newly a health physical exa advanced practice nu the first day of employ This deficient practice newly hired employee #1, #2, #3, #4, and #3 the following:	is not met as evidenced ind review of pertinent facility termined that the facility y hired employees received mination by a physician or urse within two weeks prior to yment or upon employment. e was identified for 5 of 5 e files reviewed (Employee 5), and was evidenced by		S1405 –8:39-19.5 (a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurs or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advance	d se,	

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		C
		03015	B. WING		C 06/01/2023
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
AUREL E	BROOK REHABILITATIO	N AND HEALTHCAR	URCH ROAD LAUREL, NJ 08	2054	
(X4) ID	SUMMARY S		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLE
S1405	Continued From pag	e 4	S1405		
	from the Licensed N	ursing Home Administrator		practice nurse's examination may be	
		ve randomly selected newly		deferred for up to 30 days from the first	t l
		s including their health files		day of employment. The facility shall	
	for review.			establish criteria for determining the	
				completeness of physical examinations	s for
		AM, the surveyor received		employees.	
		files and was informed two		1. Human Resources Manager was	,
		s never started working at the rere incomplete. The		reeducated on requirements for all new employees to complete a health history	
		e three health files for		and to receive an examination perform	
	•	worked at the facility which		by a physician or advanced practice nu	
	revealed the followin	-		or New Jersey licensed physician	,
		•		assistant, within two weeks prior to the	
		nsed Practical Nurse (LPN),		first day of employment or upon	
		The employee health file		employment.	
	did not include a phy			2.Due to the nature of the deficiency, a	
		l, was hired on ^{N Exectorer 2} . The		residents have the potential to be affect	ted
	employee nealth file examination.	did not include a physical		by this practice. 3. Human Resource Manager/Designe	
		l, was hired on ^{NJ Exec Order 26} The		will ensure completeness of physical	
		did not include a physical		examinations during classroom orienta	tion
	examination.			prior to any staff member being release	
				to complete on the floor training.	
	On 5/26/23 at 10:16	AM, the surveyor interviewed		4. The NHA/Designee will review all ne	w
		HR) who stated her job		hire files to ensure the completeness o	f
		v hires was to ensure they		employee physicals. Findings will be	
		ed vaccinations, schedule a		reported monthly to the QAPI meeting	until
		s test, and completed health		substantial compliance has been met.	
		ns. HR stated Agency staff health physical examination		5. Date when corrective action will be completed: June 12, 2023	
		d facility staff had in the past			
		ians at the facility including			
		as well as the facility			
		obtain a health physical			
	•	starting. HR continued the			
		obtain a health physical			
		as possible if the Medical			
		able, but staff started working			
	÷ .	having a health physical			
	examination. HR sta	ated when she received the			
PRINTED: 06/05/2024 FORM APPROVED

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON		(X3) DATE COMF	SURVEY
			A. BUILDING:			
		03015	B. WING		C 06/01/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, Z	IP CODE		
AUREL B	BROOK REHABILITATIO	N AND HEAI THCAR	URCH ROAD LAUREL, NJ 08054			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CC		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLET DATE
S1405	Continued From pag	e 5	S1405			
	the examination in the confirmed Employee Employee #3 did not examination. At this two additional emplo policy for new hires. On 5/26/23 at 10:48 the LNHA, Director of Infection Preventionia employee health pro- IP/LPN stated newly one of a two step tub orientation, and emp examinations were the should be completed surveyor informed the that the three employ included health phys LNHA confirmed the should have been co On 5/26/23 at 11:07 surveyor with the two requested. The LNH these employees did examinations either, completed upon hire The surveyor reviewe employee files which Employee #4, a Cert was hired on Employee #5, a Reg	loyee health physical ne responsibility of HR and upon hire. At this time, the e LNHA, DON, and IP/LPN vee files reviewed had not ical examinations. The health examination physicals mpleted upon hire. AM, the LNHA provided the o additional employee files A acknowledged at this time, not have health physical and should have been det the two additional revealed the following: ified Nursing Aide (CNA), The employee health file				

X61G11

PRINTED: 06/05/2024 FORM APPROVED

STATEMEN	sey Department of Hea FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONS		DATE SURVEY
	SI CONRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		
		03015	B. WING		C 06/01/2023
IAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE, ZI	PCODE	
AUREL B	BROOK REHABILITATIO	Ν ΔΝΟ ΗΕΔΙ ΤΗCΔR	URCH ROAD		
	CUMMADY C		LAUREL, NJ 08054	PROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
S1405	Continued From pag	e 6	S1405		
	of the DON, Regional Services, and survey employee health phy completed at oriental an RN assessment we examination complet advanced practice nu A review of the facilit Examinations (Physic potential employee, a offer of employment,	y team acknowledged vsical examinations should be tion, or on orientation have with a health physical used by a physician or urse within thirty days of hire. y's undated "Medical cals)" policy includedeach after receiving a conditional and each current employee eccessitates such must			

X61G11

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
315524 _{Y1}	B. Wing	Y2	7/17/2023	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL BROOK REHABILITATIO	N 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		Y5	Y4		Y5
ID Prefix	F0697	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.25(k)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		06/12/2023						
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								
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		
REVIEWE STATE AC		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF	SURVEYOR	1	DATE	
REVIEWE CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOW	UP TO SURVEY C	OMPLETED ON				S. WAS A SUMMARY OF IT TO THE FACILITY?		
Form CMS	6 - 2567B (09/92)	EF (11/06)	-	Page 1 of 1		EVENT II	D: X61G12	

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
	A. Building			
315524 _{Y1}	B. Wing	Y2	7/17/2023	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL BROOK REHABILITATIO	N 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	M	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix Reg. # LSC	F0609 483.12(b)(5)(i)(A) (1)(4)	Correction (B)(c) 06/12/2023	ID Prefix Reg. # LSC	F0610 483.12(c)(2)-(4)	Correction Completed	ID Prefix Reg. # LSC	F0658 483.21(b)(3)(i)		Correction Completed 06/12/2023
ID Prefix Reg. # LSC	F0697 483.25(k)	Correction Completed 06/12/2023	ID Prefix Reg. # LSC	F0759 483.45(f)(1)	Correction Completed	ID Prefix Reg. # LSC	F0761 483.45(g)(h)(1)(2)		Correction Completed 06/12/2023
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
REVIEWE STATE AG		REVIEWED BY (INITIALS) REVIEWED BY	DATE	SIGNATURE OF	SURVEYOR	I		DATE	
6/1/2023	UP TO SURVEY C			CK FOR ANY UNCORREC DRRECTED DEFICIENCIE Page 1 of 1				YES X61G12	

STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DATE OF REVISIT	
	B. Wing	Y2	7/17/2023	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL BROOK REHABILITATIO	N 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).

ITEM		DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix S0560		Correction	ID Prefix	S1405		Correction	ID Prefix			Correction
8:39-5.1(a) Reg. #		Completed	Reg. #	8:39-19.	5(a)	Completed	Reg. #			Completed
LSC		06/12/2023	LSC			06/12/2023	LSC			Completed
						_				
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
		Completed	Bog #			Completed	Bog #			Completed
Reg. # 		Completed	Reg. #			Completed	Reg. #			Completed
			LSC			_	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC			_	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC			_	LSC			
REVIEWED BY STATE AGENCY		EWED BY ALS)	DATE		SIGNATURE OF S	URVEYOR			DATE	
REVIEWED BY CMS RO		EWED BY ALS)	DATE		TITLE				DATE	
FOLLOWUP TO SURV 6/1/2023	EY COMPLE	FED ON			ANY UNCORRECTE ED DEFICIENCIES					
					Page 1 of 1			EVENT ID:	X61G12	

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
ATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING 01	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		315524	B. WING		06/01/2023
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER	3718	EET ADDRESS, CITY, STATE, ZIP CODE 3 CHURCH ROAD JNT 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTIC
K 000	INITIAL COMMENTS		K 000		
	stated to be around 1 renovations or noted building Type II (000) sprinklered. The build gas generators 30 an approximately 60% o 2-elevators have fire top and bottom of eac Maintenance Director	f the building. The sprinkler protection at the ch shaft as per the			
	the corridors, spaces resident rooms. The g is stated to be tied to cross corridor door he door releases, emerg safety components uf	open to the corridors and in generator outside the facility the fire alarm control panel, old open devices, exterior ency facility lighting and life ilized for preservation of life ertified beds. At the time of			
	The requirement at 4. NOT MET as evidence	2 CFR Subpart 483.90(a) is ed by:			
K 222 SS=E	Egress Doors CFR(s): NFPA 101		K 222		6/12/23
	equipped with a latch use of a tool or key fr using one of the follow arrangements: CLINICAL NEEDS OF LOCKING Where special locking	neans of egress shall not be or a lock that requires the om the egress side unless wing special locking R SECURITY THREAT g arrangements for the s of the patient are used,			
DRATORY I	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>	TITLE	(X6) DATE
Electroni	cally Signed				06/16/20

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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	S FOR MEDICARE &		()(0)			0.0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 01	(X3) DATE COMF	SURVEY PLETED
		315524	B. WING		06/	01/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
LAUREL E	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
K 222	Continued From page	e 1	K 22	2		
	-	ce shall be permitted on		-		
		ions shall be made for the				
		pants by: remote control of				
		cks or keys carried by staff at				
		ch reliable means available				
	to the staff at all times					
		2.6, 19.2.2.2.5.1, 19.2.2.2.6 DCKING ARRANGEMENTS				
		g arrangements for the				
		atient are used, all of the				
		ocking requirements are				
	being met. In additior	n, the locks must be				
		ail safely so as to release				
		the device; the building is				
		vised automatic sprinkler				
	complete smoke dete	ed space is protected by a				
		at an attended location				
		ce); and both the sprinkler				
	and detection system	is are arranged to unlock the				
	doors upon activation					
	18.2.2.2.5.2, 19.2.2.2					
	DELAYED-EGRESS	LOCKING				
	ARRANGEMENTS	yed-egress locking systems				
		ce with 7.2.1.6.1 shall be				
		semblies serving low and				
		ents in buildings protected				
		proved, supervised automatic				
	-	or an approved, supervised				
	automatic sprinkler sy	•				
	18.2.2.2.4, 19.2.2.2.4	LED EGRESS LOCKING				
	ARRANGEMENTS					
	-	gress Door assemblies				
	Installed in accordance	ce with 7.2.1.6.2 shall be				
	normittad					
	permitted. 18.2.2.2.4, 19.2.2.2.4	L				

Facility ID: NJ03015

If continuation sheet Page 2 of 14

		MEDICAID SERVICES			OMB NO. 0938		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	<i>.</i>	
		315524	B. WING		06/01/202	3	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL E	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPL	LETIO	
K 222	Continued From page	e 2	K 22	2			
	ELEVATOR LOBBY	EXIT ACCESS LOCKING		-			
	ARRANGEMENTS						
	Elevator lobby exit ac	1.6.3 shall be permitted on					
		uildings protected throughout					
	by an approved, supe						
		l an approved, supervised					
	automatic sprinkler sy	•					
	18.2.2.2.4, 19.2.2.2.4						
		is not met as evidenced					
	by:	and interview in the		K222 Egross Deers CEB(a): NEB	101		
		n and interview, in the ance Director and Plant		K222 Egress Doors CFR(s): NFPA Doors in a required means of egres			
	· ·	on 5/17/23, it was determined		not be equipped with a latch or a lo			
	-	to provide exit doors in the		requires the use of a tool or key fro			
	means of egress read	dily accessible and free of all		egress side unless using one of the	e		
	· ·	liments to full instant use in		following special locking arrangeme	ents:		
	the case of fire or oth			CLINICAL NEEDS OR SECURITY			
		requirements of NFPA 101,		THREAT LOCKING.	4 . f		
	and 19.2.2.2.6 for 2 c	19.2.2.2.5.1, 19.2.2.2.5.2		Where special locking arrangemen			
	exit/egress doors obs			the clinical security needs of the pa are used, only one locking device s			
				permitted on each door and provisi			
	This deficient practice	e was identified for 2 of 2		shall be made for the rapid remova			
	sets of doors and was	s evidenced as follows:		occupants by: remote control of loc keying of all locks or keys carried b	ks;		
	On 5/17/23 at 11:08 A	AM, the survevor.		at all times; or other such reliable n			
		r (MD), and Regional Plant		available to the staff at all times.			
		RPOD) observed two sets of		18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5	.1,		
		cated at the front entrance of		19.2.2.2.6			
	•	r and exit set of sliding doors		SPECIAL NEEDS LOCKING			
		gaged a hook-type deadbolt.		ARRANGEMENTS Where special	-		
		or could restrict emergency		arrangements for the safety needs			
		urrent evacuation plan nt doors were designated an		patient are used, all of the Clinical Security Locking requirements are			
		e two-sets of sliding door		met. In addition, the locks must be			
	had signs indicating p	-		electrical locks that fail safely so as	to		
	emergency, but with	-		release upon loss of power to the c			
		ure would not open the doors		the building is protected by a super			

Facility ID: NJ03015

If continuation sheet Page 3 of 14

ATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DAT	IO. 0938-039
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G 01	CON	MPLETED
		315524	B. WING		0	6/01/2023
AME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		ON AND HEALTHCARE CENTER		3718 CHURCH ROAD		
				MOUNT LAUREL, NJ 08054		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP		COMPLETIO DATE
IAG			170	DEFICIENCY)		
K 000		•				
K 222	Continued From page		K 22		ha laaliad	
	as stated on the sigr	15.		automatic sprinkler system and t space is protected by a complete		
	At the time of the ob	servation, the surveyor		detection system (or is constant		
		and RPOD who stated that		monitored at an attended locatio	•	
		be deadbolt) could restrict use		the locked space); and both the	sprinkler	
	of the exit from the e	egress-side in the event of an		and detection systems are arran		
	emergency.			unlock the doors upon activation		
	The Lisses of Norma			18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12	2-4	
		ng Home Administrator was gs at the Life Safety Code		DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, lis	tod	
	Exit Conference on s			delayed-egress locking systems		
		6, 16, 20.		in accordance with 7.2.1.6.1 sha		
	NJAC 8:39-31.2(e)			permitted on door assemblies se	rving low	
	NFPA 101, 2012 Edi	tion, Section - 19.2.2.2.5.1,		and ordinary hazard contents in		
	19.2.2.2.5.2 and 19.			protected throughout by an appro		
	NFPA 101:2012 Edit	tion, Section - 7.2.1.6.1.1(3)C		supervised automatic fire detecti		
				system or an approved, supervis		
				automatic sprinkler system. 18.2 19.2.2.2.4	.2.2.4,	
				ACCESS-CONTROLLED EGRE	SS	
				LOCKING ARRANGEMENTS		
				Access-Controlled Egress Door		
				assemblies installed in accordan		
				7.2.1.6.2 shall be permitted. 18.2	2.2.2.4,	
					20	
				ELEVATOR LOBBY EXIT ACCE LOCKING ARRANGEMENTS EI		
				lobby exit access door locking in		
				accordance with 7.2.1.6.3 shall b		
				permitted on door assemblies in		
				protected throughout by an appro		
				supervised automatic fire detecti		
				system and an approved, superv		
				automatic sprinkler system. 18.2 19.2.2.2.4	.2.2.4,	
				1. Lockset that engaged a hook-	wne	
				deadbolt has been removed and	• •	
				with a non-locking mechanism th	•	

Event ID: X61G21

Facility ID: NJ03015

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PRINTED: 06/05/2024 FORM APPROVED

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		315524	B. WING		06/01/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL E	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE EFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL TORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPORTION		BE COMPLE		
K 222	Continued From page	e 4	K 22:	2 restrict the emergency use of the exit 2. All residents, staff, and visitors hav potential to be affected by this practic	ve the	
				 3.Audit completed on all emergency is doors to ensure that no other emerged door in the facility is equipped with a lockset that engages a hook-type deadbolt. Any and all identified, hook deadbolt lockset have been removed replaced with a non-locking mechanis not restrict the emergency use of the Maintenance Director or Designee to conduct audits weekly x4, bi-weekly x5 for three months and then monthly. 4. Audit findings will be reviewed monthy by the Interdisciplinary Team at the C committee meeting until substantial compliance has been met. 5. Date when corrective action will be completed: June 12, 2023 	exit ency -type, and sm to exit. k2, hthly API	
K 321 SS=E	Hazardous Areas - E Hazardous areas are having 1-hour fire res fire rated doors) or ar system in accordance When the approved a	nclosure protected by a fire barrier sistance rating (with 3/4 hour n automatic fire extinguishing e with 8.7.1 or 19.3.5.9. automatic fire extinguishing	K 32	1	7/15/23	
	partitions and doors i Doors shall be self-cl and permitted to have protective plates that from the bottom of th Describe the floor an	spaces by smoke resisting n accordance with 8.4. osing or automatic-closing e nonrated or field-applied do not exceed 48 inches e door.				

Facility ID: NJ03015

If continuation sheet Page 5 of 14

		MEDICAID SERVICES			OMB NO. 0938-03		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
		315524	B. WING		06/01/2023		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL E	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIC		
K 321	Continued From page 19.3.2.1, 19.3.5.9	ə 5	K 32 ⁻	1			
	e. Trash Collection Re (exceeding 64 gallons f. Combustible Storag (over 50 square feet) g. Laboratories (if class Hazard - see K322) This REQUIREMENT by: Based on observatio review on 5/18/23, in Maintenance Director Director, and Vice Pre determined that the fa barrier with two-hour accordance with NFP 19.3.2.1 and 8.7.1. The evidenced for 1 of 5 h On 5/18/23 at 11:10 A the boiler room that a by eight feet (8' x 4') s missing and falling do wallboard exposed fa unprotected wood. The protected in fire-rated The findings were ver Director, Regional Pla	ed Heater Rooms han 100 square feet) ce, and Paint Shops is (exceeding 64 gallons) coms s) ge Rooms/Spaces ssified as Severe • is not met as evidenced n, interview, and document the presence of the r, Regional Plant Operations esident of Operations, it was acility failed to provide a fire fire resistance rating in rA 101, 2012 Edition, Section he deficient practice was hazardous areas observed. AM, the surveyor observed in n approximately eight feet section of wallboard was hown. The missing section of lling insulation and he area was now not fully		K321 Hazardous Areas – Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardo areas are protected by a fire barrier having 1-hour fire resistance rating (w 3/4 hour fire rated doors) or an automa fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the appro automatic fire extinguishing system op is used, the areas shall be separated other spaces by smoke resisting partit and doors in accordance with 8.4. Doo shall be self-closing or automatic closi and permitted to have nonrated or field applied protective plates that do not exceed 48 inches from the bottom of t door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3 Area Automatic Sprinkler Separation N a. Boiler and Fuel-Fired Heater Room Laundries (larger than 100 square fee Repair, Maintenance, and Paint Shop	ith atic ce oved otion from ions ors ng d he .5.9 N/A s b. t) c.		

Event ID: X61G21

Facility ID: NJ03015

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SU	0938-039
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLE	
		315524	B. WING		06/01	/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL I	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 321	Continued From pag	e 6	K 32 ⁻			
	The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit conference on 5/18/23. NJAC 8:39-31.2(e)			 Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 squ feet) g. Laboratories (if classified as Severe Hazard - see K322) 1. The approximate eight feet by eigh (8' x 4') section of wallboard that was missing and falling down and the mis section of wallboard exposed falling insulation and unprotected wood hav been repaired. 2. All residents, staff, and visitors hav potential to be affected by this practic 3. Maintenance Director conducted w through audit to ensure that no wallboards, falling insulation, unprotected 	are ht feet sing e ve the ce . valk	
K 341 SS=D	components approve accordance with NFF	Installation s installed with systems and	K 34	 wood are exposed. Any and all wallboards, falling insulation, unprote and exposed wood has been remove and repaired accordingly. Maintenand Director or Designee to conduct audi weekly x4, bi-weekly x2, and then monthly. 4. Audit findings will be reviewed more by the Interdisciplinary Team at the C committee meeting until substantial compliance has been met. 5. Date when corrective action will be completed: July 15, 2023 	ed ce ts nthly API	15/23

Facility ID: NJ03015

If continuation sheet Page 7 of 14

	S FOR MEDICARE &				OMB NO. 0938-0	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		315524	B. WING		06/01/2023	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL I	BROOK REHABILITATIO	N AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET	
K 341	building. In areas not detection is installed unit. In new occupand at notification applian and supervising statio	ning of fire in any part of the continuously occupied, at each fire alarm control cy, detection is also installed ce circuit power extenders, on transmitting equipment. ring or other transmission for integrity.	K 341	1		
	by: Based on observatio in the presence of the was determined that fire alarm notification signals for 1 of 1 encl accordance with NFP Section 19.3.4.3.1, 9 NFPA 72, 2010 LSC I 18.5.2.4, 24.4.2.20.9 The deficient practice following: On 5/17/23 at 11:20 A Maintenance Director enclosed courtyard, r notification (horn/stro An interview was con observation and the s	A 101, 2012 LSC Edition , 0.6.3, 9.6.3.2, 9.6.3.6 and Edition, Section 18.5, a was evidenced by the AM, the surveyor and r (MD) observed in the main no evidence of a fire alarm be) device. ducted during the surveyor asked the MD, if be, tied into the fire alarm		K341 Fire Alarm System – Installatt Fire Alarm System - Installation A fir alarm system is installed with syste and components approved for the purpose in accordance with NFPA 7 National Electric Code, and NFPA 7 National Fire Alarm Code to provide effective warning of fire in any part building. In areas not continuously occupied, detection is installed at ea fire alarm control unit. In new occup detection is also installed at notifica appliance circuit power extenders, a supervising station transmitting equipment. Fire alarm system wiring other transmission paths are monito for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 1. Horn/strobe device tied into the finalarm system in the enclosed courty has been installed. 2. All residents, staff, and visitors has	re ms 70, 72, 22, 23 of the 24 of the 24 of the 24 of the 25 of th	

Facility ID: NJ03015

If continuation sheet Page 8 of 14

		MEDICAID SERVICES			OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING (E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315524	B. WING		06/01/2023	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUREL B	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		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 PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE COMPLÉTIO	
K 341	Continued From page	8	K 341			
	enclosed courtyard of			audit to ensure effective warning of fi	e is	
	The Licensed Nursing notified of the findings conference on 5/18/2	g Home Administrator was s at the Life Safety Code exit		provided at all parts of the building. No other areas warranting additional components identified. Maintenance Director or Designee to conduct audit weekly x4, bi-weekly x2, and then	ło	
	9.6.3, 9.6.3.2, 9.6.3.	Edition , Section 19.3.4.3.1, 6 and NFPA 72, 2010 LSC 18.5.2.4, 24.4.2.20.9		 monthly. 4. Findings will be reported monthly to QAPI committee meeting until substation compliance has been met. 5. Date when corrective action will be completed: July 15, 2023 	ntial	
K 374 SS=E	Subdivision of Buildin CFR(s): NFPA 101	g Spaces - Smoke Barrie	K 374		7/15/23	
	Doors 2012 EXISTING Doors in smoke barrie bonded wood-core do resists fire for 20 minu plates of unlimited he are permitted to have assemblies per 8.5. D automatic-closing, do are not required to sw egress travel. Door of clear width of 32 inch doors. 19.3.7.6, 19.3.7.8, 19 This REQUIREMENT by: Based on observatio in the presence of the Regional Plant Operation	Doors are self-closing or not require latching, and ving in the direction of pening provides a minimum es for swinging or horizontal		K374 Subdivision of Building Spaces Smoke Barrier CFR(s): NFPA 101 Subdivision of Building Spaces - Smo Barrier Doors 2012 EXISTING Doors	ke	

Event ID: X61G21

Facility ID: NJ03015

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		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION 01	· · ·	TE SURVEY MPLETED
		315524	B. WING		06/01/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAUREL B	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
K 374	Continued From page	9	K 37	4		
	in accordance with NI Section 19.3.7, 19.3.7 8.5.4, 8.5.4.1. This deficient practice sets of double smoke tested for closure, an following: 1. On 5/18/23 at 10:4 observed that the set employee lounge, wh auto-magnetic hold-o were observed to be twelve inches (12") m of doors not being sm allow the transfer of s gasses to pass from o another in the event o integrity of the smoke 2. On 5/18/23 at 11:1 that the set of smoke when closed were no gap between the doo size. This would allow and poisonous gasse compartment to anoth compromising the inter The Maintenance Dire Operations Director, a	of smoke doors by the en released from the pen device fully closed, compromised at the bottom leeting point, due to the set noke resistant. This would smoke, fire and poisonous one smoke compartment to of a fire compromising the e zone. 0 AM, the surveyor observed doors by the East-wing spa, t fully smoke resistant as the rs was approximately 1/4" in v the transfer of smoke, fire s to pass from one smoke her in the event of a fire egrity of the smoke zone. ector, Regional Plant and Vice President of hed the findings during the		 construction that resists fire for minutes. Nonrated protective p unlimited height are permitted. permitted to have fixed fire wir assemblies per 8.5. Doors are or automatic closing, do not re- latching, and are not required the direction of egress travel. If opening provides a minimum of of 32 inches for swinging or ho doors. 19.3.7.6, 19.3.7.8, 19.3 1. The two sets of smoke door deemed to not be smoke resis when closed were not fully sm resistant as the gap between t was approximately 1/4" in size replaced. 2. All residents, staff, and visit potential to be affected by this 3. Maintenance Director condu- building walk through audit to a smoke barrier wall doors comp to resist the passage of smoke gases. Any and all smoke barri that were found to not complet have been repaired. Maintena or Designee to conduct audits bi-weekly x2, and then monthly 4. Monitor Corrective Actions: be reported monthly to the QA committee meeting until substa compliance has been met. 5. Date when corrective action completed: July 15, 2023 	olates of Doors are dow self-closing quire to swing in Door clear width vizontal .7.9 s that were tant due to oke he doors , have been ors have the practice. ucted ensure that oletely close e, flame, or ier walls ely close nce Director weekly x4, /. Findings will Pl antial	
	-	g Home Administrator was gs at the Life Safety Code 18/23.				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/05/202 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED
		315524	B. WING		06/01/2023
NAME OF PI	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	•
LAURELE		N AND HEALTHCARE CENTER		3718 CHURCH ROAD	
2/1011222				MOUNT LAUREL, NJ 08054	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
K 374	Continued From page	e 10	K 37	4	
	NJAC 8:39-31.2(e)				
K 521			K 52	1	6/12/23
SS=E	-				
	HVAC Heating, ventilation, a comply with 9.2 and s accordance with the r specifications. 18.5.2.1, 19.5.2.1, 9.2	manufacturer's			
	by: Based on observatio in the presence of the Regional Plant Operato President of Operatio the facility failed to er ventilation systems w and operating in optir with the National Fire (NFPA) 90 A. This de identified for 32 of 10 vents observed and v following: While touring the buil AM to approximately the Maintenance Dire Operations Director (I of Operations (VPO) systems did not funct piece of single-ply toi	0 resident room bathrooms		 K521 HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with th manufacturer's specifications. 18.5.2. 19.5.2.1, 9.2 1. Ventilation system was assessed by Maintenance Director and found to ha faulty motor that resulted in a malfunct to the ventilation system. The motor w repaired and ventilation system is now functioning properly. 2. All residents, staff, and visitors on th East Unit have the potential to be affeed by this practice. 3. Maintenance Director conducted far audit to ensure HVAC Heating, ventilatian and air conditioning shall be fully operational and in compliance with manufacturers' specifications. Facility deemed all ventilations systems to be 	ne 1, ve a tion vas v he cted cility tion

Event ID: X61G21

Facility ID: NJ03015

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		MEDICAID SERVICES				D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 01	(X3) DATE COMF	E SURVEY PLETED
		315524	B. WING		06/01/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUREL E	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 521	Continued From page	e 11	K 52 ⁻			
	 tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. The resident room bathrooms were identified on the East-wing nursing units as: #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #67, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81, #82, and #83. An interview was conducted with the MD during the observations, and he confirmed the findings. The MD stated the roof unit may have a bad motor and/or a broken fan belt. He stated currently the facility ventilation system in resident rooms was not functioning and the facility did not have a ventilation inspection log or operating 			 working properly. Maintenance Direction Designee to conduct audits weekly bi-weekly x2, and then monthly. 4. Findings will be reported monthly QAPI committee meeting until substance has been met. 5. Date when corrective action will be completed: June 12, 2023 	x4, to the tantial	
	informed of the findin exit conference on 5/ NFPA 90 A Standard ventilating systems					
	NJAC 8:39-31.2(e)	J.Z. I SCUIUT J.Z. I ATU J.Z.Z				
K 911 SS=D	Electrical Systems - 0	Other	K 91 ⁻	1		6/12/23
	Chapter 6 Electrical S are not addressed by are deficient. This infi applicable Life Safety	Other Section any NFPA 99 Systems requirements that the provided K-Tags, but ormation, along with the Code or NFPA standard cluded on Form CMS-2567.				

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	S FOR MEDICARE &					NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 01	· · ·	ATE SURVEY DMPLETED	
		315524	B. WING		06/01/2023		
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE			
LAUREL I	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		3718 CHURCH ROAD MOUNT LAUREL, NJ 08054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
K 911	Continued From page	e 12	K 91	1			
		is not met as evidenced					
	 Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation on 5/18/23, in the presence of the Maintenance Director, Regional Plant Operations Director, and Vice President of Operations, the facility failed to demonstrate reliability regarding fuel supply in accordance with NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4. for 2 of 2 generators. This deficient practice was evidenced by the following: On 2/23/23 at 12:05 PM, the surveyor and Maintenance Director (MD) reviewed all the facility's generator documentation. The facility currently had two interior 85 and 30 KW (kilowatt) natural gas generators. The MD could not produce a documented reliability letter from the natural gas provider. Reliability letters from the natural gas vendor regarding fuel supply must contain all of the following: 			 K911 Electrical Systems – Other NFPA 101 Electrical Systems - Other List in REMARKS section any NFPA 98 6 Electrical Systems requirement are not addressed by the provide K-Tags, but are deficient. This information, along with the applic Safety Code or NFPA standard of should be included on Form CME Chapter 6 (NFPA 99) 1. Facility attained reliability letter natural gas provider, Public Serve Electric & Gas Company, on 05/2. All residents, staff, and visitors potential to be affected by this provider on K911 to ensure compliance is maintained. 4. Administrator/Designee will erreliability letter is updated as neer yearly at a minimum. Findings wireported to the QAPI committee 	a the Chapter ts that ed cable Life citation, S-2567. er from vice 18/23. have the ractice. educated shoure that eded and ill be		
	natural gas delivery. 2. A brief description regarding the reliabilit 3. A statement that th interruption of the nat 4. A brief description regarding the low pro	ere is a low probability of		until compliance has been met. 5. Date when corrective action w completed: June 12, 2023	/ill be		

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY			
	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 0			E SURVEY IPLETED		
		315524	B. WING		06/01/2023			
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP	CODE	DE		
AUREL E	BROOK REHABILITATIO	N AND HEALTHCARE CENTER		718 CHURCH ROAD IOUNT LAUREL, NJ 08054				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE		
K 911	Continued From page	e 13	K 911					
	natural gas generato	tural gas provider for the two rs for the facility to present to itional information was						
		g Home Administrator was ngs at the Life Safety Code 18/23.						
	NJAC 8:39-31.2(e) NFPA 99, 2012 Editio 2010 Edition, Sectior	on Chapter 6 and NFPA 110, n 5.1.4.						

Facility ID: NJ03015

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POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - LAUREL BROOK REHABILIT						
315524 _{Y1}	B. Wing						
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE					
LAUREL BROOK REHABILITATIO	N 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			Y5	Y4			Y5
ID Prefix Reg. # LSC	NFPA 101	Correction Completed 06/12/2023	ID Prefix Reg. # LSC	NFPA 10)1	Correction Completed 07/15/2023	ID Prefix Reg. # LSC	NFPA 101 K0341		Correction Completed 07/15/2023
ID Prefix Reg. # LSC	NFPA 101 K0374	Correction Completed 07/15/2023	ID Prefix Reg. # LSC	NFPA 10 K0521)1	Correction Completed 06/12/2023	ID Prefix Reg. # LSC	NFPA 101 K0911		Correction Completed 06/12/2023
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction	ID Prefix Reg. # LSC			Correction Completed
REVIEWE STATE AC		REVIEWED BY (INITIALS)	DATE		SIGNATURE OF	SURVEYOR			DATE	
6/1/2023						ED DEFICIENCIES S (CMS-2567) SEN			DATE	