STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315437	A. BUILDING _____ B. WING _____	C 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BAY HEALTH & REHABILITATION CENTER	**32 LAUREL AVENUE KEANSBURG, NJ 07734**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #: NJ 161492, NJ 161690, NJ 164297 Survey Date: 1/18/2024 Census: 82 Sample: 19+2 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		3/5/24

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

Electronically Signed | 02/05/2024

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F 580	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint #NJ00164297 Based on interviews, review of medical records and other facility documentation, it was determined that the facility failed to notify a family	F 580	F580 1. Resident #192 NJ Ex Order 26.4(b)(1) at the facility.	

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F 580	Continued From page 2 representative when a resident had a significant change in NJ Ex Order 26.4(b)(1). This deficient practice was identified for 1 of 18 residents (Resident #192) reviewed. This deficient practice was evidenced by: Review of Resident #192's closed electronic health record (EHR) revealed an Admission Record (an admission summary) which indicated that the resident was admitted to the facility with diagnosis which included but were not limited to: NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1), NJ Ex Order 2 and NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) Review of Resident #192's most recent quarterly Minimum Data Set (MDS), an assessment tool, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated that the resident was NJ Ex Order 26.4(b)(. Further review of the MDS revealed that the resident required supervision and set up assistance for NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) and NJ Ex Order 26 and ambulated with a walker. Review of Resident #192's Progress Notes (PN) revealed a Health Status Note dated NJ Ex Order 26.4(at 18:11 (6:11 PM) documented by the U.S. FOIA (b) (6) , 'U.S. FOIA (b) (6)) made writer aware of resident's NJ Ex Order 26.4(b)(1) , while NJ Ex Order 26.4(b) Downgraded to NJ Ex Order 26.4 until NJ Ex Order 26.4(evaluation." The entry failed to demonstrate the the resident's responsible party or family was notified.	F 580	2. All Resident have the potential to be at risk for not being notified. Nursing staff was reeducated by the Director of Nursing on the facility policy for family notifications. All charts were reviewed to ensure family notifications were made related to the following circumstances: (A) an injury which had the potential for requiring physician intervention: (B) significant change in the resident's physical, mental, or psychosocial status: (C) A need to alter treatment significantly; (D) Resident transfers and discharges; (E) A change in room or roommate assignment; (F) A change in resident rights under Federal or State law or regulations After reviews were made, notifications were made to the residents, families, physicians, & resident representatives as needed. 3. Random chart audits will be conducted on residents with (A) documented accidents resulting in an injury. (B) significant change in the resident's	

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F 580	Continued From page 3 Further review of Resident #192's PNs revealed a Health Status Note dated [NJ Ex Order 26.4(b)(1)] at 21:03 (9:05 PM) documented by the [U.S. FOIA (b) (6)]) and indicated, '[U.S. FOIA (b) (6)]) made aware resident is [NJ Ex Order 26.4(b)(1)]. Ok to down grade to [NJ Ex Order 26.4(b)(1)] and follow up with [NJ Ex Order 26.4(b)(1)] There was no documented evidence to indicate that the resident's responsible party or family was notified. Review of Resident #192's Order Summary Report revealed that on [NJ Ex Order 26.4(b)(1)] the resident was ordered a [NJ Ex Order 26.4(b)(1)] with [NJ Ex Order 26.4(b)(1)], and [NJ Ex Order 26.4(b)(1)] Review of Resident #192's Care Plan revealed an entry initiated on [NJ Ex Order 26.4(b)(1)] and revised/resolved date of [NJ Ex Order 26.4(b)(1)] with a Focus which indicated the following: "to safely and efficiently [NJ Ex Order 26.4(b)(1)]." The previous entry dated [NJ Ex Order 26.4(b)(1)] revealed the following: "I [NJ Ex Order 26.4(b)(1)] declined in my [NJ Ex Order 26.4(b)(1)] to [NJ Ex Order 26.4(b)(1)]." Interventions initiated on [NJ Ex Order 26.4(b)(1)] and resolved on [NJ Ex Order 26.4(b)(1)] included: "Please provide me with [NJ Ex Order 26.4(b)(1)]) intervention to assess and improve my [NJ Ex Order 26.4(b)(1)], provide [NJ Ex Order 26.4(b)(1)], analysis and determination of least [NJ Ex Order 26.4(b)(1)] and appropriate [NJ Ex Order 26.4(b)(1)] training and ed (education) with techniques to facilitate safety and maximize [NJ Ex Order 26.4(b)(1)] n." During an interview with the surveyor on 1/5/24 at 11:41 AM, the [U.S. FOIA (b) (6)] provided the surveyor with email correspondence between the facility and Resident #192's family which involved the family bringing [NJ Ex Order 26.4(b)(1)] for the resident. The [U.S. FOIA (b) (6)] explained that when the family brought [NJ Ex Order 26.4(b)(1)]	F 580	physical, mental, or psychosocial status. (C) Episodes where treatment was altered significantly. (D) Resident transfers and discharges (E) Any change in room or roommate assignment Administrator or designee will monitor any and all changes in Federal or State law or regulations & advise residents & resident representatives as needed. 4. 2 random audits will be performed by the Director of Nursing or designee 2x weekly for 2 quarters and then quarterly thereafter. The information will be brought to QAPI committee for review. QAPI will follow for 6 months.	

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F 580	Continued From page 4	F 580		

NJ Ex Order 26 to the facility for the resident they did not know that the resident's NJ Ex Or had been changed to a NJ Ex Order 26.4(b)(1).

During a later interview with the surveyor on 1/5/24 at 12:41 PM, the U.S. FOIA (b stated that the U.S. FOIA (b) (6)) was responsible to call Resident #192's family and document that they were notified when the resident's NJ Ex Or was downgraded. The U.S. FOIA (b further stated that she was pretty sure that the U.S. FO missed calling the family in the EHR because there was no documentation to indicate that she had. The U.S. FOIA (b further explained that the family should have been notified because they probably would not have brought the NJ Ex Order 26.4(b)(1) in had they known. The surveyor asked the U.S. FOIA (b what could have happened if the resident were permitted to eat the NJ Ex Order 26.4(b)(1) The U.S. FOIA (b stated, "The resident could have NJ Ex Order 26.4(b)(

On 1/8/24 at 10:42 AM the surveyor interviewed CNA #1 who stated that she was Resident #192's permanent aide. CNA #1 stated that the resident was on a NJ Ex Order 26.4(b)(1) and required NJ Ex Order 26.4(CNA #1 stated that when the resident's family visited in NJ Ex Order 26.4(b)(1), they brought the resident NJ Ex Order 26.4(b)(1) and the CNA explained that she removed it from the resident as the family did not know the resident could not have NJ Ex Order 26.4(b)(1) because their NJ Ex Or was changed.

During an interview with the surveyor on 1/8/23 at 11:01 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that when a resident was identified to have NJ Ex Order 26.4(b)(1) , nursing assessed the resident, downgraded NJ Ex Order 26.4(b) got a NJ Ex Order 26.4(evaluation consult, and notified everyone involved in the

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F 580	Continued From page 5	F 580		

resident's care. LPN #1 further stated that he would also document family and doctor notification in the health notes.

During an interview with the surveyor on 1/9/24 at 10:23 AM, the [U.S. FO] stated that it was her responsibility to monitor the resident's [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)(1)], [NJ Ex Order 26.4(b)] and problems with [NJ Ex Order 26.4(b)] and [NJ Ex Order 26.4(b)(1)]. The [U.S. FO] explained that Resident #192 was on a [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4] until his/her CNA reported that the resident was [NJ Ex Order 26.4(b)(1)]. The [U.S. FO] stated that the resident's nurse was notified and the resident was referred to [NJ Ex Order 26.4] for evaluation. [U.S. FO] stated that when she saw the resident next, the order had already been changed to [NJ Ex Order 26.4(b)] [U.S. FO] stated, "Whoever was taking care of the resident that day, after the [NJ Ex Order 26.4(b)(1)] evaluation I would think would have handled contacting the family at that time." [U.S. FO] further explained that either the nurse or the NJ Ex Order 26.4(b)(1) could have notified the family. [U.S. FO] stated, "the family would have to be notified of a change in [NJ Ex Order 26.4(b)(1)] for [NJ Ex Order 26.4(b)(1)], as a change in [NJ Ex Order 26.4(b)(1)] notification would prevent someone from NJ Ex Order 26.4(b)(1) The [U.S. FO] further stated that the resident would be at risk for [NJ Ex Order 26.4(b)] if offered [NJ Ex Order 26.4(b)(1)]

During an interview with the surveyor on 1/9/24 at 10:37 AM, the U.S. FOIA (b) (6)) stated that Resident #192 was seen from [NJ Ex Order 26.4(b)] through [NJ Ex Order 26.4(b)] for [NJ Ex Order 26.4(b)] She stated that the resident had difficulty with NJ Ex Order 26.4(b)(1) and was [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b)] stated that the recommendation was for a [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b)] explained that nursing was responsible to do the follow-up notifications with both the family and the

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F 580	Continued From page 6 physician. During an interview with the surveyor on 1/9/24 at 10:37 AM, the [U.S. FOIA (b] stated that Resident #192's family should have been notified by the [U.S. FO] once the final speech recommendations were made to inform the family of the [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b] further stated that there was no documention in the EHR to indicate that the family was notified that the resident's [NJ Ex Or] was changed to [NJ Ex Order 2] as required. Review of the facility's undated policy, "Notification-Physician-Family" Policy #N-4.1 revealed the following: The resident, family, significant other, legal representative, responsible party, and/or physician shall be notified of any of the following: ...In the event that the resident requires any treatment from a professional discipline, such as occupational, physical, or speech therapies, consultations, or other therapeutic services. ...All notifications should be in writing, in the medical record. Review of the facility's undated policy, "Resident Care" Policy # c-19.1, revealed the following: Resident change in condition will be assessed promptly and follow up activity will occur as appropriate and in a timely fashion. Procedure: Resident change in condition is reported immediately to the licensed nurse by the staff person from who first notices the change. The resident's primary physician or designated alternate will be consulted immediately of a significant change in resident's physical, mental, or psychosocial status. The resident, or the residents' designated medical contact or guardian will also be notified...Notification of physician	F 580		

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F 580	Continued From page 7 and/or responsible parties shall be documented in the clinical record as well as on the 24 hour report form. Status changes which are not significant enough to be reported must be documented in the medical record. NJAC 8:39-13.1 (c)	F 580		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to conduct a new NJ Exec Order 26.4b1 [redacted] assessment after a resident was newly diagnosed with NJ Ex Order 26.4(b)(1). This deficient practice was identified in 1 of 5	F 644	F644 1. New NJ Exec Order 26.4b1 screen was completed for resident 80. 2. All residents have the potential to be affected by not meeting the requirements	3/5/24

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F 644	Continued From page 8 residents reviewed for NJ Exec Order 26.4b (Resident #80) and was evidenced by the following: On 01/03/24 at 10:55 AM, the surveyor reviewed Resident #80's Electronic Medical Record (EMR) which indicated that the resident had a NJ Exec Order 26.4 NJ Exec Order 26 completed on NJ Ex Order 26.4(b)(. At the time of the assessment the assessment was marked NJ Ex Ord for any diagnoses of NJ Ex Order 26.4(b)(1) Resident #80 was admitted to the facility with diagnoses which included, but were not limited to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1) Review of the admission Minimum Data Set (MDS), an assessment tool, revealed the resident's Brief Interview of Mental Status was unable to be completed due to NJ Ex Order 26.4(b)(1) . On 01/03/24 at 11:30 AM, the surveyor reviewed section I titled "active diagnoses" of the residents' MDS. The admission MDS dated NJ Ex Order 26.4(b)(did not included NJ Ex Order 26.4(b)(1) , and the discharge/return anticipated MDS dated NJ Ex Order 26.4(b)(did not include any NJ Ex Order 26.4(b)(1) . The discharge/return anticipated MDS dated NJ Ex Order 26.4(did not include a NJ Ex Order 26.4(b)(1) , the quarterly MDS dated NJ Ex Order 26.4(b)(and NJ Ex Order 26.4(b)(did not include any NJ Ex Order 26.4(b)(1) Further MDS review reflected that the quarterly MDS dated NJ Ex Order 26.4(b)(, NJ Ex Order 26.4(b)(and NJ Ex Order 26.4(b)(indicated the resident had diagnoses of NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) . On 01/08/24 at 12:19 PM, the surveyor reviewed the residents initial NJ Ex Order 26.4(b)(consult dated NJ Ex Order 26.4(b) It was documented that the resident had NJ Ex Order 26.4(b)(1) requiring medications.	F 644	of conducting a new Preadmission Screening and Resident Review (PASRR) level 1 assessment after a resident was newly diagnosed with NJ Ex Order 26.4(b)(1) . All resident PASRR Level 1 screens were reviewed by Social worker for accuracy and updated as needed 3. Social services was reeducated by the administrator on proper policy and procedure for completing PASRR (Level 1) assessment after a resident was newly diagnosed with a mental illness. Social worker to review accuracy of all PASRR Level 1 screens upon admission and readmission and as needed upon new mental illness diagnosis. Social worker to review all PASRR level 1 screens quarterly for accuracy and complete rescreens upon new mental illness diagnosis and as needed. The DON/ Designee will inform Social worker of all residents newly diagnosed with a serious mental illness or intellectual disability, and social services will complete a new PASRR Level 1 screen on the resident. 4. Social Service Director or designee will audit all PASRR□s 1x monthly for the next 3 months, and quarterly thereafter. The Social Service Director or Designee will present all findings to Administrator and at the quarterly QAPI meeting for review.	

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F 644	Continued From page 9 On 01/09/24 at 10:38 AM, the surveyor interviewed the facility U.S. FOIA (b) (6) regarding Resident #80 NJ Exec Order 26.4b1. The surveyor asked if the resident needed a NJ Exec Order 26.4b1 to be completed again since a new NJ Ex Order 26.4(b)(1) diagnosis and the U.S. FOI said, "Since no hospitalization or symptoms, [the resident]didn't it, it didn't' affect [the resident's] NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) or anything. It was [the resident's] I just would read the first NJ Exec Order 26.4b1 "Maybe I would do one." On 01/11/24 at 09:53 AM, the surveyor interviewed the U.S. FOIA (b) (6) who confirmed that the NJ Exec Order 26.4 was not completed as required when there was a new NJ Ex Order 26.4(b)(1) diagnosis. On 01/11/24 at 10:40 AM, the surveyor reviewed the policy titled, "Procedure for PASSR Level I and Level II, an undated policy. The policy indicated that upon admission the SW will review the Level I or Level II on the medical record. The SW will make changes as appropriate. The policy also revealed the upon notification of a change in status, the SW will review the Level I and Level II on the medical record. The SW will make changes as appropriate.	F 644	QAPI will follow for 4 months.	
F 728 SS=D	NJAC 8:39-27.1 (a) Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in	F 728		3/5/24

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F 728	Continued From page 10 the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility allowed a Non-Certified Nursing Aide (NA) to continue working as an NA after the specified 120 days from date of hire. This deficient practice	F 728	F728 1. NA#1 was removed from the schedule on 1-9-24	

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	315437	A. BUILDING _____ B. WING _____	C 01/18/2024

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F 728	Continued From page 11 was identified for 1 NA, (NA #1) during the NA review. This deficient practice was evidenced by the following: Reference: State of New Jersey Department of Health memo dated April 21, 2023, sent to Nursing Homes included the following: Facilities are advised as follows: II. Nurse Aides Nurse Aides (not TNAs) who are enrolled in a NATCEP program must finish training and pass the nurse-aide written or oral exam and the State approved clinical skills competency exam within the usual 120 days, pursuant to N.J.A.C. 8:39-43.1. After completing the first 16 hours of training, the nurse aide may work in a nursing home while completing the training and testing. On 1/4/23 at 11:50 AM, the surveyor reviewed the facility provided Certified Nursing Assistant (CNA) list. Nursing Assistant (NA) #1 was listed as being a NA with a start date of [NJ Ex Order 26.4(], and noted a "written date o[NJ Ex Order 26.4(b)(1)] A review of the daily staffing for 1/4/24 revealed that NA #1 was scheduled to work on the 1st floor as a CNA for the 3-11 shift. During an interview with the surveyor on 1/09/24 at 10:24 AM, the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] stated that NA #1 should have become certified as a CNA within 120 days of hire but there were "some exceptions." The [U.S. FOIA (b)] stated that the facility was following a waiver which gave the facility additional time and that	F 728	2. All residents have the potential to be affected by a non certified NA. All employee files were reviewed by Human Resources Director to ensure that the facility was not employing any additional NAs. No other NAs were identified. 3. [U.S. FOIA (b) (6)] was reeducated by the Assistant Director of Nursing on requirement for facility hiring and use of nurse aides, use of non-permanent employees & minimum competency requirements for NAs. In addition, a flow sheet was created to be used by the HR department for future NA hires. The flow sheet will denote the employees hire date, skills test date with proof of passing, school progress, written test date, employees 120th day of employment. Flow sheet will be updated by HR every 30 days until the employee becomes certified or exhausts the allotted 120 days. 4. Human Resources Director will give monthly NA status update reports to the administrator for review. Human Resources Director will share NA status reports with the QAPI committee quarterly for review. QAPI will follow for 4 months.	

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F 728	Continued From page 12 there was an extension because there was trouble scheduling tests. During an interview with the surveyor on 1/9/24 at 11:34 AM, [U.S. FO] stated that NA #1 was going to be removed off of the schedule. During a follow up interview with the surveyor on 1/10/23 at 10:13 AM, the [U.S. FOIA (b] stated that NA #1 attended CNA school from [NJ Ex Order 26.4(b)] through [NJ Ex Order 26.4(b)]. She stated NA #1 took the required skills test on [NJ Ex Order 26.4(b)(1] The [U.S. FOIA (b] stated that NA #1 should have been certified by [NJ Ex Order 26.4(b)(1)] The [U.S. FOIA (b] confirmed that NA #1 has worked at the facility as a NA on the nursing unit providing direct care since [NJ Ex Order 26.4(b)(1] without a certification. A review of the November 2023 calendar for NA #1 reflected that NA #1 was scheduled to work as follows: 11/13/23 and 11/14/23 evening and night shift, 11/16/23 evening shift, 11/17/23, 11/18/23, 11/19/23, 11/21/23 evening and night shift, 11/23/23 evening shift, 11/24/23, 11/27/23, 11/28/23 evening and night shift, and 11/30/23 evening shift. (13 days with no certification) A review of the December 2023 calendar for NA#1 reflects that NA #1 was scheduled to work as follows: 12/1/23 evening shift, 12/2/23 and 12/3/23 evening shift and night shift, 12/4/23 and 12/6/23 evening shift, 12/7/23 evening and night shift, 12/8/23 evening shift, 12/11/23, 12/12/23/12/14/23, 12/16/23, 12/17/23 evening shift and night shift. 12/19/23 evening shift, 12/21/23 evening shift and night shift, 12/22/23 night shift, 12/25/23 and 12/26/23 evening shift and night shift, 12/27/23 evening shift, 12/28/23,	F 728		

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F 728	Continued From page 13 12/30/23, and 12/31/23 evening and night shift. (22 days with no certification) A review of the January 2024 calendar for NA #1 reflected that NA #1 was scheduled to work as follows: 1/2/24 and 1/3/24 night shift, 1/4/24 evening and night shift, 1/5/24 evening shift, and 1/8/24 evening and night shift. (5 days with no certification) A review of the facility provided policy Nursing Assistant (Uncertified) with a review date of 3/14/18, reflects that an employee must pass the competency evaluation program (skills and written/oral examination) within 120 days of employment. A review of the facility provided employee job description for Certified Nursing Assistant reflects under general qualifications that one must have certification as nursing assistant in this state. N.J.A.C. 8:39-43.10	F 728		

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H 000	Initials Comments The facility is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedures and Standards Applicable To All Licensed Facilities.	H 000		
H3470	8:43E-10.11(c)(2) Other Rprtng Rqrmnts Unrltd to Pt Sfty Act Examples of reportable events in the nature of physical plant and operational interruptions, include, but are not limited to, the following: Loss or significant reduction of water, electrical power, or any other essential utilities necessary to the operation of the facility. This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility documentation, it was determined that the facility failed to report the occurrence of a dishwasher failure to the New Jersey Department of Health (NJDOH). This deficient practice was evidenced by the following: During the kitchen tour on January 3, 2024, at 9:30 AM, the surveyor interviewed the Food Service Director who stated that the dishwasher was "repaired last night." Paper products/utensils were in place for resident meals and the three-sink system was in place for washing of utensils/pots during the period of time that the dishwasher was not working.	H3470	H3470 1. Dishwasher was fixed on January 2nd 2024. 2. All residents have the potential to be at risk when essential utilities are not working. All systems related to water, electrical power, or any other essential utilities necessary to the operation of the facility were checked by the Director of Maintenance and found to be in working order. 3. Reeducation was given to facility management & Administrator by the Facility Chief Operations Officer in regards	3/5/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/05/24

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H3470	Continued From page 1 On January 3, 2024, at 10:15 AM, the surveyor interviewed the Administrator who stated the dishwasher had been broken since December 11, 2023. A review of the documentation provided by the facility, revealed that the repair company visited the facility on December 15, 2023; however, the technician did not have all the parts needed with him at that time. During an interview with the surveyor on January 4, 2024, at 10:34 AM, the Administrator stated that when the dishwasher was down, he did not report it in to the NJDOH as "he wasn't sure if it had to be called in."	H3470	to reportable events in the nature of physical plant and operational interruptions. 4. All physical plant reportable events will be reported per regulations & reviewed by the facility Chief Operations Officer to ensure timely reporting was completed. Administrator will review this at the Quarterly QAPI meeting. QAPI will follow for 4 months	
S 000	Initial Comments Complaint # NJ 161492, NJ 164297 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.	S 560		3/5/24

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S 560	Continued From page 2 This REQUIREMENT is not met as evidenced by: Complaint # NJ 161492, NJ 164297 Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to: a) train the two (2) appointed designated staff members within the required time frames for the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency Virus [a virus that attacks cells that help the body fight infection] positive) program and b) maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: a. Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C 8:39 in future rulemaking.	S 560	S560 1. Administrator identified one employee representing management at the facility and one employee representing direct care staff at the facility to receive LGBTQ+ training . 2. All staff & residents at the facility have the potential to be at risk when the staff is not trained properly on the rights of LGBTQ+ residents. Facility representatives are enrolled in a certificate program that meets the requirements Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The class will take place on February 6th 2024 3. All facility staff will be reeducated on the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities , and a facility's responsibilities under the LGBTQI+ Law by the LGBTQI+ and HIV+ certified staff members. This training will be ongoing for current employees every 2 years. All new hires will have the training within 12 months of hire. Attendance and completion of training will be maintained in	

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S 560	Continued From page 3 Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in long-term care facilities ("Facilities"). The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status. Prohibited Actions The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status: 1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility; 2. Denying a request by residents to share a room; 3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10 (e) (5); 4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this	S 560	the staff education log 4. Human Resources Director will monitor the in-service education logs for initial and biennial compliance. Human Resources Director will share the in-service compliance reports with the QAPI team quarterly and then annually thereafter. QAPI will follow for 4 months. S560 1. Additional contracts were signed with nursing staffing agencies to obtain additional certified nursing assistants. 2. All residents could be affected. 3. The staffing ratios will be monitored by the staffing coordinator, HR Director & DON or designee on a per shift basis. The facility will maintain current contracts with nursing staffing agencies and continue to seek out additional contracts. The facility will continue efforts to procure permanent certified nursing assistants via increased recruitment efforts, sign on bonuses, increased retention efforts, staff bonuses & overtime. 4. The staffing ratio result findings will be reviewed and reported on by the DON or designee at the Quarterly QAPI meeting. QAPI will follow for 4 months.	

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S 560	Continued From page 4 paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity; 5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice; 6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices; 7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual relations; 8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and 9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6). Resident Records Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident. Confidentiality	S 560		

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S 560	Continued From page 5 The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed. Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties. Unless expressly authorized, facility staff not directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility. Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling. Violations	S 560		

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S 560	Continued From page 6 A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action. Training Facilities shall designate two employees, including an employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey. The required training shall address: 1. Caring for LGBTQI+ seniors and seniors living with HIV; 2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status; 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ	S 560		

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S 560	Continued From page 7 community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and 7. An overview of the provisions of LGBTQI+ Law. Facilities are responsible for maintaining records documenting the completion of the training, as well as the cost of providing the training. During the entrance conference with the Administrator and the Director of Nursing (DON) on 1/3/2024 at 10:35 AM, the surveyor requested LGBTQI+ training certificates of completion for an employee representing management at the facility and one employee representing direct care staff and evidence of staff training competencies. On 1/4/24 at 9:00 AM the surveyor reviewed the requested LGBTQI+ training which included staff inservices but did not include the two certificates for management and a direct care staff training. During an interview with the surveyor on 1/4/24 at 09:20 AM, the DON stated she trained herself but didn't have a certificate or other staff certificates of training. b. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560		

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S 560	Continued From page 8 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" that were requested revealed the following: 1.For the week of Complaint staffing from 02/12/2023 to 02/18/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts and deficient in total staff for residents on 2 of 7 overnight shifts as follows: -02/12/23 had 7 CNAs for 97 residents on the day shift, required at least 12 CNAs. -02/13/23 had 8 CNAs for 97 residents on the day shift, required at least 12 CNAs. -02/13/23 had 6 total staff for 97 residents on the overnight shift, required at least 7 total staff. -02/14/23 had 6 total staff for 96 residents on the overnight shift, required at least 7 total staff. -02/15/23 had 8 CNAs for 96 residents on the day	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061333	A. BUILDING: _____ B. WING _____	C 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BAY HEALTH & REHABILITATION CEI	32 LAUREL AVENUE KEANSBURG, NJ 07734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 9 shift, required at least 12 CNAs. -02/16/23 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/17/23 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. -02/18/23 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. 2.For the week of Complaint staffing from 05/14/2023 to 05/20/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -05/14/23 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. -05/15/23 had 10 CNAs for 95 residents on the day shift, required at least 12 CNAs. -05/15/23 had 6 total staff for 95 residents on the overnight shift, required at least 7 total staff. -05/16/23 had 11 CNAs for 95 residents on the day shift, required at least 12 CNAs. -05/17/23 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs. -05/19/23 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs. 3.For the 2 weeks of staffing prior to survey from 12/17/2023 to 12/30/2023, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -12/17/23 had 8 CNAs for 87 residents on the day shift, required at least 11 CNAs. -12/20/23 had 9 CNAs for 87 residents on the day shift, required at least 11 CNAs. -12/22/23 had 10 CNAs for 96 residents on the day shift, required at least 11 CNAs. -12/23/23 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061333	A. BUILDING: _____ B. WING _____	C 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BAY HEALTH & REHABILITATION CEI	32 LAUREL AVENUE KEANSBURG, NJ 07734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 10 -12/24/23 had 7 CNAs for 81 residents on the day shift, required at least 10 CNAs. -12/26/23 had 8 CNAs for 81 residents on the day shift, required at least 10 CNAs. -12/27/23 had 8 CNAs for 81 residents on the day shift, required at least 10 CNAs. -12/28/23 had 9 CNAs for 83 residents on the day shift, required at least 10 CNAs. -12/29/23 had 9 CNAs for 82 residents on the day shift, required at least 10 CNAs. -12/30/23 had 9 CNAs for 82 residents on the day shift, required at least 10 CNAs. When interviewed on 1/04/24 at 12:15 PM, the person responsible for staffing stated that the facility tried to follow the Certified Nursing Assistant requirements. On 1/9/24 at 1:00 PM, the surveyor reviewed the Staffing (Nursing Department) policy with an issue date of 10/12/22. The policy reflects that the Nursing Department will maintain sufficient nursing staff to meet care of residents.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315437	A. Building B. Wing	3/12/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BAY HEALTH & REHABILITATION CENTER	32 LAUREL AVENUE KEANSBURG, NJ 07734

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0580 Reg. # 483.10(g)(14)(i)-(iv)(15) LSC	Correction Completed 03/05/2024	ID Prefix F0644 Reg. # 483.20(e)(1)(2) LSC	Correction Completed 03/05/2024	ID Prefix F0728 Reg. # 483.35(d)(1)-(3) LSC	Correction Completed 03/05/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/18/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061333 Y1	A. Building B. Wing Y2	3/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BAY HEALTH & REHABILITATION CENTER	32 LAUREL AVENUE KEANSBURG, NJ 07734

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix H3470 Reg. # 8:43E-10.11(c)(2) LSC	Correction Completed 03/05/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/18/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061333	A. Building B. Wing	3/12/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BAY HEALTH & REHABILITATION CENTER	32 LAUREL AVENUE KEANSBURG, NJ 07734

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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/05/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 1/18/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315437	A. BUILDING **01** B. WING _____	**01/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BAY HEALTH & REHABILITATION CENTER	**32 LAUREL AVENUE** **KEANSBURG, NJ 07734**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/18/2024 and Laurel Bay Health & Rehabilitation Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Laurel Bay Health & Rehabilitation Center is a two-story Type II Protected building that was built in 1976. The facility is divided into 8 smoke zones.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 345		3/11/24

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

Electronically Signed | 02/05/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315437	A. BUILDING 01 B. WING _____	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 1 Based on observation, interviews, and facility document review, the facility failed to inspect and test the fire dampers installed in the facility heating, ventilation, and air conditioning (HVAC) system. This deficient practice had the potential to affect all residents who currently reside in the facility. Findings included: A review of facility inspection documentation, on 01/18/2024 at 9:25 AM, revealed no evidence to indicate there was an inspection, testing, or maintenance of the facility HVAC system fire dampers. On 01/18/2024 at 11:05 AM, the surveyor, accompanied by the U.S. FOIA (b) (6), observed an access door installed on HVAC system ductwork in the Administration wing utility room. The surveyor opened the access door and observed a fire damper within the ductwork. On 01/18/2024 at 11:10 AM, the U.S. FOIA (b) (6) stated he did not know the access panel was there and had no prior knowledge of any HVAC ductwork fire dampers in the facility. The U.S. FOIA (b) (6) stated there was no written facility policy regarding the frequency and function of HVAC inspection and maintenance. In an interview on 01/18/2024 at 11:40 AM, the U.S. FOIA (b) (6) stated there was no policy on environmental rounds for the inspection of the facility ductwork. The U.S. FOIA (b) (6) stated he was not aware of the requirement of the inspection and testing of fire and/or smoke dampers in HVAC ductwork.	K 345	K345 1. (A) The maintenance director visually inspected, tested and cleaned the Fire Damper system to make sure the system was operating properly. (B) A policy and procedure for the maintenance of the Damper system was put in place (C) U.S. FOIA (b) (6) was reeducated on the requirements for the facility damper system to be tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code 2. All residents currently residing in the facility can be affected by not having an inspection, testing, or maintenance of the facility HVAC system fire dampers, 3. U.S. FOIA (b) (6) was reeducated on the requirements for inspections, testing, and maintenance of the facility HVAC system fire dampers in the in HVAC ductwork. 4. The Maintenance Director will make sure that a visual inspection of the damper systems along with testing and maintenance will be done yearly & documented. The maintenance Director will be trained by a professional company on what he needs to look for on the visual inspection. The Professional company will be coming in every 5 years to inspect. In	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315437	A. BUILDING **01** B. WING _____	**01/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BAY HEALTH & REHABILITATION CENTER	**32 LAUREL AVENUE** **KEANSBURG, NJ 07734**

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K 345	Continued From page 2 NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	addition the professional company was contacted to come out to inspect the system. Records will be reviewed on a quarterly basis to ensure that all inspections are up to date and scheduled appropriately for the coming quarter. QAPI will follow for 6 months.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315437	A. Building 01 - MAIN BUILDING 01 B. Wing	3/12/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL BAY HEALTH & REHABILITATION CENTER	32 LAUREL AVENUE KEANSBURG, NJ 07734

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 03/11/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/18/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO