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 01/07/2025

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
F 000	INITIAL COMMENTS Complaint #:NJ00177022 Survey Date:12/30/24 - 1/7/2025 Census: 78 Sample: 23 +3 closed records 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed provide services with reasonable accommodation of resident needs specifically by failing to keep call devices within reach of the resident. The deficient practice was identified 2 of 2 residents (Resident #80 and Resident # 236) reviewed for call devices. On 12/30/2024 at 10:29 AM during the initial tour of the facility, surveyor # 1 observed Resident # 236's call device on the floor next to the night stand. It was connected to the wall input.	F 558	1. A) Resident 236's call bell was secured within reach. B) Resident 80's call bell was secured within reach. 2. The DON and ADON checked all resident rooms to ensure all resident call bells were secured within reach.	2/10/25

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

Electronically Signed — 01/24/2025

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 _____ B. WING _____	C 01/07/2025

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
F 558	Continued From page 1 On 12/31/2024 at 8:58 AM, surveyor # 1 observed Resident # 236's call device on the floor next to the night stand. It appeared to be in the same location as the previous observation. At that time during an interview with surveyor # 1, Resident # 236s said they would use it if he/she could find it. On 1/06/2025 at 11:44 AM during an interview with surveyor # 1, the US FOIA (b)(6) [redacted] said they [call devices] are attached to the resident's bed, pillow, or sheet but we do have some that are wrapped around the rail or behind their head so when they lay down they can reach above. A review of the undated facility policy titled, "Call Light System" revealed that, "Unless indicated in the care plan, each resident, when in their room or in bed, must have the call light placed within reach at all times, regardless of staff assessment of resident ability to use it. When resident is in bed, the call bell should be fastened to the side rail he/she is facing..." On 12/31/2024 at 11:06 AM, surveyor #2 observed Resident #80 in their room on the bed. Surveyor #2 asked permission from Resident #80 to enter and was granted permission. Upon entering, surveyor #2 observed Resident #80's call device on the floor behind the bedside table. When asked if they knew where their call device was, Resident #80 denied. When asked if the call device was behind the dresser the resident responded that the call bell "shouldn't be there. That doesn't make sense. It wouldn't help me if I needed it".	F 558	3. A) The facility's call bell policy was reviewed by the DON. All nursing staff were re-educated by the ADON on the facility's call bell policy, which includes ensuring each resident call bell is secured within the resident's reach when they are in their bedroom. B) The DON/designee will conduct 3 random call bell audits weekly to ensure resident call bells are secured within the resident's reach and are functioning properly when pressed. Any issues found by the DON/designee will be addressed immediately. The audits will be conducted for a minimum of 6 months. 4. The DON/designee will report and review all audit findings with the QAPI committee quarterly for a minimum of 6 months.	

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 01/07/2025

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
F 558	Continued From page 2 The surveyor reviewed the medical record for Resident #80. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: [redacted] A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's [redacted] was [redacted] A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated [redacted], that the resident was "at risk for [redacted] [related to] NJ Exec Order 26.4b1, [redacted] drug use/[redacted] problems". Interventions included: Be sure call light is within reach and encourage me to use it for assistance was needed. On 1/3/2025 at 10:24 AM, surveyor #2 interviewed CNA #2 who confirmed call devices are a [redacted] and that they should be clipped to the bed or pillow and within reach of the resident. On 1/3/2025 at 12:14 PM, surveyor #2 interviewed Licensed Nurse Practitioner (LPN #1) who confirmed that call devices are to be within reach of the resident at all times. LPN #1 further confirmed that she was aware of the call device previously being behind the dresser and moved it to bed.	F 558		

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 01/07/2025

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
F 558	Continued From page 3 On 1/06/2025 at 11:44 AM during an interview with surveyor # 1, the US FOIA (b)(6) [redacted] advised that call devices are to be on the bed, pillow, or sheet. A review of the undated facility policy titled, "Call Light System" revealed that, "Unless indicated in the care plan, each resident, when in their room or in bed, must have the call light placed within reach at all times, regardless of staff assessment of resident ability to use it. When resident is in bed, the call bell should be fastened to the side rail he/she is facing..."	F 558		
F 584 SS=E	NJAC 8:39-27.1 (a) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		2/20/25

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 01/07/2025

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
F 584	Continued From page 4 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to keep all areas clean. The deficient practice was identified for 2 of 2 floors reviewed under the Environmental Task. The deficient practice was evidenced by the following: On 12/30/2024 at 10:31 AM, Surveyor # 1 observed Room 14. At that time, Surveyor # 1 observed water on the floor. No wet-floor sign was observed. On the same date at 10:37 AM, Surveyor # 1 observed Resident # 35 in their room. At that time, Surveyor # 1 observed spilled milk on the	F 584	F584 Immediate 1. The observed water on the floor was wiped up and the responsible staff was instructed to place the missing wet floor sign at the area until dry. 2. The observed spilled milk was cleaned from the floor and a bag liner installed in the trash bin. Staff were in-serviced on the importance of keeping liners in the waste receptacles. 3. The first-floor shower room across from room 21was cleaned to remove the brown stains on the floor, tile, and caulked areas. 4. The exposed dry wall behind the measuring scale had appropriate wall tiles	

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 01/07/2025

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
F 584	Continued From page 5 floor and no bag liner in the trash bin. On 12/31/2024 at 11:03 AM, Surveyor # 1 observed the first floor shower room across from room 21. At that time, Surveyor # 1 observed brown stains on the floor, tile, and caulked areas. Exposed dry wall was also observed to be present behind the measuring scale. On 1/06/2025 at 11:44 AM during an interview with Surveyor # 1, the US FOIA (b)(6) said that resident rooms are cleaned on a daily basis. the US FOIA (b) also said that it is a shared responsibility to contain spills and pick up discarded items on the floor. B.) On 12/31/2024 at 9:43 AM, Surveyor #2 observed embedded black and gray marks on the bathroom floor in room 229 on the second floor. On 01/02/2025 at 9:12 AM, Surveyor #2 observed that the trash can in room 225 on the second floor was missing a bag liner. On 01/02/2025 at 10:04 AM, Surveyor #2 observed missing floor tiles on the second-floor shower room, which exposed a brown substance around the drain. There were also missing tiles at the entrance to the shower area. Additionally, several wall tiles around the heater vent and sink were absent, revealing a gray substance. The wall tile covered by a white board showed a hole in the wall. During an interview with Surveyor #2 on 12/06/2024 at 11:40 AM, the US FOIA (b)(6) said that general cleaning of the facility is conducted daily and as needed. Housekeeping is responsible for changing trash can liners, while Certified Nursing Assistants	F 584	installed. 5. The embedded black and gray marks on the bathroom floor in room 229 on the second floor were cleaned. 6. The trash can in room 225 on the second floor had a liner installed and staff were in-serviced on the importance of keeping liners in the waste receptacles. 7. The missing floor tiles on the second-floor shower room, which exposed a brown substance around the drain were replaced. 8. The missing tiles at the entrance to the shower area and several wall tiles around the heater vent and sink were installed 9. The wall whiteboard was removed, and the hole was repaired. 10. The facility has created an updated policy for housekeeping and maintenance. Others The facility respectfully states that no were residents were directly involved however all had the potential to be affected by this deficient practice. Other areas were checked and all areas are in compliance. Systemic Changes 1. Requirements for staff responsibility and accountability relative to environment and maintenance issues has been in-serviced. 2. Responsibility of the Quality Assurance Committee and morning meeting to track and identify any quality issues related to the environment of care. 3- Inservice education will be provided to involved staff by Housekeeping Director.	

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 01/07/2025

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
F 584	Continued From page 6 (CNAs) are tasked with emptying trash and replacing liners if they fill the trash cans. Maintenance logs are kept and updated on the nursing units, and maintenance conducts regular walk-throughs to address any issues identified in the facility. The facility was unable to provide a policy regarding the environment conditions in the facility. N.J.A.C. 8:39-31.3(a)	F 584	b. A copy of the Lesson Plan and Attendance will be filed for reference and validation. 4. The Administrator in conjunction with the Director of Housekeeping/Maintenance has developed a schedule for cleaning and repair to address all the deficiencies identified in the Deficiency Statement as well as a daily assignment to ensure ongoing compliance. 5.The Facility Administrator has implemented daily Environment Rounds on all units. 6. Findings of rounds will be documented on a “rounds sheet” with directives for corrective action assignments by the Administrator and/or Housekeeping/Maintenance Director. Findings on rounds will be followed for corrective actions and assignment completion daily as an ongoing tracking and QA. 8. The Director of Maintenance/Housekeeping will attend the daily morning meeting and staff will actively communicate and track environment concerns and maintenance issues for any needed repairs or corrective actions. All staff will understand that the Environment and Maintenance is everyone’s responsibility! 9.The Morning meeting will have attendance documented and communication will be a ongoing Quality Assurance method to ensure consistent compliance with our plan of corrections, as well as ongoing environment/maintenance compliance.	

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 01/07/2025

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
F 584	Continued From page 7	F 584	10. The facility has reviewed and revised the housekeeping and maintenance reporting and scheduling policies. IV. Quality Assurance Monitoring: Based on the Quality Assurance Meeting, the Facility has implemented an enhanced QAPI program including a communication system to report environmental and maintenance concerns, which will be communicated daily at the morning meeting, as well as daily QA environment and maintenance rounds. The communication by involved staff will be documented on a "daily morning meeting tracking sheet" for ongoing corrective actions and quality assurance monitoring by the Administrator and Director of Housekeeping/Maintenance. 5. The administrator has developed a QA Environment Rounds tool for daily rounds as a QAPI monitoring tool. 6. As per Systemic Changes; environment rounds will be done daily (M-F) on all units, and findings will be documented on the Environment Rounds sheet. 7. Based on findings of the QA Environment Rounds; assignments will be made for corrective actions to ensure ongoing corrections and consistent compliance. 8. Findings of QA Environment rounds will be discussed at the scheduled QA Meeting chaired by the Administrator, for ongoing compliance and overall awareness by staff. Responsible Discipline: Administrator Date of Completion: 02/20/25	
F 641 SS=D	Accuracy of Assessments	F 641		2/10/25

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 01/07/2025

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
F 641	Continued From page 8 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately assess the status of a resident in the Minimum Data Set (MDS), an assessment tool used to facilitate care. This deficient practice was identified for 1 of 23 residents (Resident #80) reviewed and was evidenced by the following: Upon initial tour of the facility on 12/30/2024 at 10:44 AM, Resident #80 was observed [NJ Exec Order 26.4b1] by the [NJ Exec Order 26.4b1] nursing station. The surveyor observed an [NJ Exec Order 26.4b1] device on the resident's [NJ Exec Order 26.4b1]. On 12/31/2024 at 11:06 AM, the surveyor observed Resident #80 sitting on their bed in their room. The surveyor asked permission from Resident #80 to enter and was granted permission. Resident #80 acknowledged the presence of the [NJ Exec Order 26.4b] on the [NJ Exec Order 26.4b1], but did not know what it was. The surveyor reviewed the medical record for Resident #80. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: [NJ Exec Order 26.4b1] [redacted] A review of the resident's quarterly Minimum Data	F 641	1.Resident 80's MDS was corrected to reflect the use of a [NJ Exec Order 26.4b1] [redacted] and resubmitted to CMS. 2.MDS (s) of all residents using wander/elopement alarms were reviewed by the DON for coding accuracy. 3. A) The DON reviewed the facility's MDS 3.0 policy. The [US FOIA (b)(6)] was re-educated by the DON on the facility's MDS 3.0 policy and the need for accurate assessments when completing an MDS. B) The DON/designee will conduct 2 random MDS audits weekly to ensure accurate completion for a minimum of 6 months. Any issues found by the DON/designee will be addressed immediately. 4. The DON /designee will report and review all audit findings with the QAPI committee quarterly for a minimum of 6 months.	

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 01/07/2025

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
F 641	Continued From page 9 Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 [redacted]. Section NJ Exec Order 2[redacted] reflected that the resident was coded as [redacted] indicating there was no NJ Exec Order 26.4b1 alarm. A review of the Electronic Medical Record included the following physician orders (PO): A PO, dated NJ Exec Order 26.4b1, for [NJ Exec Order 26.4b1 NJ Ex Order 26.4[redacted]] to NJ Exec Order 26.4b1. Check placement. A review of NJ Exec Order 26.4b1 Treatment Administration Record revealed a check and nurses initials confirming the physician's order of "[NJ Exec Order 26.4b1 NJ Ex Order 26.[redacted]] to NJ Exec Order 26.4b1. Check placement". On 1/7/2025 at 9:13 AM, the surveyor interviewed the US FOIA (b)(6) who confirmed that she completed section [redacted] of the MDS. The US FOIA (b)[redacted] reviewed Resident #80's physician orders and confirmed an order for a NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1. Upon reviewing the resident's Quarterly MDS dated NJ Exec Order 26.4b1, the US FOIA (b)(6) confirmed the section was coded as [redacted] indicating there was no NJ Exec Order 26.4b1. A review of the facility's "MDS 3.0", dated 10/1/2010, policy included the following Purpose: the MDS 3.0 assessment will be conducted to identify problems in order to develop and implement an individualized and comprehensive plan of care that provides each resident with the care and services to attain or maintain their	F 641		

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 01/07/2025

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
F 641	Continued From page 10 highest practicable physical, mental, and psychosocial well being. NJAC 8:39-11.1	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		2/10/25

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 01/07/2025

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
F 656	Continued From page 11 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation interview and record review, it was determined that the facility failed to develop and implement a care plan focus for 1 of 2 residents (Resident #68) reviewed for comprehensive care plans related to [redacted] care. This deficient practice was evidenced by the following: During initial tour on 12/30/2024 at 09:48 AM, the surveyor observed Resident # 68 resting in bed with a [redacted] attached to the bed frame. A review of the Admission Record located in the Electronic Medical Record, Resident #68 was admitted to the facility with diagnoses including but not limited to: [redacted]).	F 656	1.Resident 68's care plan was updated. 2.All resident care plans were reviewed by the DON and ADON for accuracy. Care plans were updated as needed. 3. A) The DON reviewed the facility's Interdisciplinary Care Plan policy. The licensed nursing staff including the [redacted] were re-educated on the facility's Interdisciplinary Care Plan policy by the DON. B) The DON/designee will conduct 2 random care plan audits weekly to ensure care plans are accurate and updated as needed for a minimum of 3 months. Any issues found by the DON/designee will be addressed immediately. 4. The DON/designee will report and review all audit findings with the QAPI committee quarterly for a minimum of 3 months.	

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 01/07/2025

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
F 656	Continued From page 12 A review of the current Care Plan (CP) for Resident #68 did not include documentation of a CP focus area or interventions for the care of [redacted]. During an interview on 1/03/2025 at 10:50 AM with the surveyor, the [redacted] said CPs are updated quarterly and as needed if anything changes in the resident's medical care. When asked if Resident # 68 should be care planned for an [redacted], the [redacted] replied, "Yes, it should have been updated the night [redacted] came back". A review of a facility provided policy titled "Care Plans-Interdisciplinary" revealed under section "Procedure" that, "3. The Interdisciplinary Care Plan will be periodically reviewed and revised after each resident's annual assessment, quarterly reviews, and upon any significant change in condition. The care plan shall also be updated warranted by a change of medications or treatments or other changes in condition." NJAC 8:39-27.1(a)	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review and document review it was determined that the facility a) failed	F 658	1. A) Resident 80□s physician order was updated to reflect placement of the	2/10/25

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 01/07/2025

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
F 658	Continued From page 13 to follow a physician's placement order of an [redacted] and b) signed the Treatment Administration Record (TAR) that identified correct placement of the [redacted] per physician's order. This deficient practice was identified for 1 of 1 Residents (Resident #80) reviewed for [redacted] and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.". On 12/30/2024 at 10:44 AM, upon initial tour of the facility, Resident #80 was observed [redacted] by the [redacted] nursing station. The	F 658	resident□s [redacted] to the [redacted] B) Resident 80□s care plan was updated to reflect placement of the resident□s [redacted] to the [redacted] 2. A) The DON and ADON reviewed the orders of all residents utilizing wanderguards to ensure the physician□s orders reflect the correct placement of the wanderguard for each resident. B) The DON and ADON reviewed the care plans of all residents utilizing wanderguards to ensure the care plans reflect the correct placement of the wanderguard for each resident. 3. A) The DON reviewed the facility□s Wandeguard Transmitter Application policy. The licensed nursing staff was re-educated by the ADON on the facility□s Wanderguard Transmitter Application policy. B) The facility's Documentation Guideline policy was reviewed by the DON. The licensed nursing staff was re-educated by the ADON on the facility□s Documentation Guideline Policy. C) The ADON/designee will conduct 3 random audits weekly to ensure physician□s orders are being carried out and documented correctly for a minimum	

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 01/07/2025

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
F 658	Continued From page 14 surveyor observed an [NJ Exec Order 26.4b1] [NJ Ex Order 26] on the resident's [NJ Exec Order 26.4b1] On 12/31/2024 at 11:06 AM, the surveyor observed Resident #80 sitting on their bed in their room. The surveyor asked permission from Resident #80 to enter and was granted permission. Resident #80 acknowledged that the [NJ Exec Order 26.4b1] was on their [NJ Exec Order 26.4b1] but did not know what it was. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: [NJ Exec Order 26.4b1] [redacted] A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [NJ Exec Order 26.4b1] included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's [NJ Exec Order 26.4b1] was [NJ Exec Order 26.4b1] [redacted] A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated [NJ Exec Order 26.4b1], that the resident was "at risk for [NJ Exec Order 26.4b1]. Interventions included: Provide [NJ Exec Order 26.4b1] [NJ Ex Order 26] to [NJ Exec Order 26.4b1]. Check function every week on Friday 7-3 shift and check placement every shift. A review of the Electronic Medical Record included the following physician orders (PO): A PO, dated [NJ Exec Order 26.4b1], for [NJ Exec Order 26.4b1] [NJ Ex Order 26] to [NJ Exec Order 26.4b1]. Check placement.	F 658	of 6 months. Any issues found by the ADON/designee will be addressed immediately. 4. The ADON/designee will report and review all audit findings with the QAPI committee quarterly for a minimum of 6 months.	

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 01/07/2025

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
F 658	Continued From page 15 A PO, dated [NJ Exec Order 26.4b1], to check function of [NJ Exec Order 26.4b1 NJ Ex Order 26] to [NJ Exec Order 26.4b1]. A review of [NJ Exec Order 26.4b1] TAR revealed a check and nurses initials confirming the physician's order of [NJ Exec Order 26.4b1] to [NJ Exec Order 2] Check placement". On 1/3/2025 at 11:50 AM, the surveyor interviewed Licensed Nurse Practitioner (LPN #1) that the nurses will take the physician's orders and are responsible for ensuring that the orders are being accurately followed. On the same date and time, LPN #1 reviewed the [NJ Exec Order 26.4b1] device orders for Resident #80. LPN #1 and the surveyor entered Resident #80's room with permission. At this time, LPN #1 confirmed that the [NJ Exec Order 26.4b1] was on the resident's [NJ Exec Order 26.4b1]. LPN #1 also acknowledged that the Treatment Administration Record was being checked off weekly confirming placement on the [NJ Exec Order] A review of the facility's undated "Documentation Guidelines" Policy included: 1. To chart in the medical record correctly; a. Documentation is to be done in the resident's medical record via the Electronic Medical Record (EMR); b. Entries are to be signed electronically by the staff member making the entry. A review of the facility's policy titled "Wanderguard transmitter application", dated 9/19/2011, included: Orders will be written to check the placement of the transmitter every shift and check the function of the transmitter weekly. NJAC 8:39-27.1(a)	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		2/10/25

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 01/07/2025

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
F 689	Continued From page 16 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of pertinent facility documents it was determined that the facility failed to ensure the resident's environment is free from accident hazards specifically by failing to place a [NJ Exec Order 26.] beside the bed while the resident is in bed. The deficient practice was identified for 1 of 3 residents (Resident # 81) investigated for [NJ Exec Or] and 1 of 1 residents (Resident # 75) investigated for Accident Hazards. The deficient practice was evidenced by the following: A review of Resident # 81's quarterly Minimum Data Set (MDS; An assessment tool) dated [NJ Exec Order 26.4b1] revealed that he/she had a f[NJ Exec Order 26.4b1] upon admission. A review of Resident # 81's physician's orders located in the Electronic Medical Record (EMR) revealed an order for an [NJ Exec Order 26.4] [NJ Exec Order 26.4] with a [NJ Exec Order 26.4b1] every shift. A review of Resident # 81's Care Plans located in the EMR revealed a focus for risk for [NJ Exec O] related to NJ Exec Order 26.4b1	F 689	1. A) Resident 81□s [NJ Exec Order 26.4b1] was put in place as ordered. B) Resident 75□s [NJ Exec Order 26.4b1] was put in place as ordered. 2. The rooms of all residents utilizing crash mats were checked by the ADON and DON to ensure crash mats were in place as ordered. 3. A) The facility□s Fall Prevention policy was reviewed by the DON. The nursing staff was re-educated on the facility□s Fall Prevention Policy by the ADON. B) The ADON/designee will conduct 3 random audits weekly to ensure accident prevention interventions are in place and carried out as ordered for a minimum of 3 months. Any issues found by the ADON/designee will be addressed immediately.	

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 01/07/2025

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
F 689	Continued From page 17 NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1. The focus also revealed dates when Resident # 81 was NJ Exec Order on NJ Exec Order 26.4b1. The dates are as follows: NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 On 01/02/2025 at 9:31 AM while observing the resident in bed in their room, Surveyor # 1 observed the NJ Ex Order 26.4b1 folded and resting upon the wall. At that time, Resident # 81 stated that he/she has NJ Exec Order 26.4b1 in the past. On 01/06/2025 at 11:11 AM while observing the resident in their room, Surveyor # 1 observed the NJ Exec Order 26.4b1 folded and placed on the side. On 01/06/2025 at 11:44 AM during an interview with Surveyor # 1, the US FOIA (b)(6) replied, "When they are in bed." when the surveyor asked If a resident has an order or intervention for NJ Exec Order 26.4b1, where and when should they be placed. Lastly, the US FOIA (b) replied, "It should not." when the surveyor asked should NJ Exec O be folded up towards the wall when the resident is in bed. A review of the facility policy dated 2/4/20 titled, "Falls" revealed under section "e" that, "If a resident tries to climb out of bed, bed should be adjusted to the lowest level and a floor mattress	F 689	4. The ADON/designee will report and review all audit findings with the QAPI committee quarterly for a minimum of 3 months.	

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 01/07/2025

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
F 689	Continued From page 18 should be on the floor. One side of the bed, may be put against the wall." 2.) During the initial tour of the unit on 12/30/2024 at 9:32 AM, surveyor #2 met Licensed Practical Nurse (LPN#1) and obtained basic information regarding the floor. LPN #1 explained that on the resident's name placard an NJ Exec Order 26.4b1 would indicate a NJ Exec Order 26.4b1. On the same date at 9:48 AM, surveyor #2 observed Resident #75 in bed. Across from the bed, surveyor #2 observed a NJ Exec Order 26.4b1 folded upright against the wall. On 12/31/2024 at 9:22 AM, surveyor #2 observed Room # NJ Exec with an open door. Surveyor observed Resident #75 in bed and the NJ Exec Order 26.4b1 folded upright against the wall. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Exec Order 26.4b1. A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 included the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated the resident's NJ Exec Order 26.4b1 as NJ Exec Order 26.4b1. A review of the resident's individual comprehensive care plan (ICCP) included focus areas that revealed NJ Exec Order 26.4b1 with following dates NJ Exec Order 26.4b1 Interventions included: NJ Exec Order 26.4b1 with NJ Exec Orde	F 689		

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 01/07/2025

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
F 689	Continued From page 19	F 689		

NJ Exec O

A review of the Order Summary Report (OSR), dated as of NJ Exec Order 26.4b, included the following physician orders (PO):

A PO, dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1 with NJ Exec Order 26.4b on the floor every shift for safety.

On 1/3/2025 at 10:24 AM, surveyor #2 interviewed CNA #2 who advised that they have received education on NJ Exec O and NJ Exec Order 26.4b1. CNA #2 explained that NJ Exec Order 26.4b are to be placed on the floor whenever the resident is in bed.

On 1/3/2025 at 11:50 AM, surveyor #2 interviewed Licensed Nurse Practitioner (LPN #1) who confirmed that Resident #75 was a NJ Exec Order 26 and that they are to have a NJ Ex Order 26.4b with NJ Exec Order 26. When asked how the NJ Exec Order 26.4b is to be applied, LPN #1 explained that when the resident is in bed the NJ Exec Order 26 is to be on the floor.

On 1/06/2025 at 11:44 AM, during an interview with surveyor # 1, the US FOIA (b)(6)) confirmed that NJ Exec Order 26.4b1 should not be folded up towards the wall when the resident is in bed.

On 1/7/2025 at 8:35 AM, surveyor #2 interviewed the US FOIA (b)(6) confirmed that ordered NJ Exec Order 26.4b1 are to be on the NJ Exec O next to the resident whenever they are in bed.

A review of the facility's "Falls" Policy, dated 2/4/2020, included under the Policy Statement: It is policy of Laurel Bay to maintain a highest possible safe environment for all resident to decrease and minimize the risk and incident of falls. The following was identified under the

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 01/07/2025

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
F 689	Continued From page 20 Interventions heading: e. If a resident tries to climb out of bed, bed should be adjusted to the lowest level and a floor mattress should be on the floor. One side of the bed may to be put again the wall.	F 689		
F 690 SS=D	NJAC 8:39-33.1(d) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		2/10/25

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 01/07/2025

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
F 690	Continued From page 21 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Complaint # NJ00177022 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that there were a.) physicians orders for an NJ Exec Order 26.4b1 b.) ensure NJ Exec Order 26.4b1 were secured in manner to prevent contamination and infection control; c.) failed to document the NJ Exec Order 26.4b1 was collected as ordered by the physician. and that for 2 of 2 resident reviewed for an NJ Exec Order 26.4b1. (Resident #68 and Resident #21). The deficient practice was evidenced by the following: 1. During the initial tour on 12/30/2024 at 09:48AM, surveyor #1 observed Resident # 68's NJ Exec Order 26.4b1 not in a NJ Exec Order 26.4b1 and visable from the hallway. On 01/02/2025 at 09:40 AM surveyor # 1 observed Resident # 68's NJ Exec Order 26.4b1 in a NJ Exec Order 26.4b1 touching the floor. According to the Admission Record, Resident #68 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1	F 690	1. A) Resident 68□s NJ Exec Order 26.4b1 was placed in a NJ Exec Order 26.4b1 and properly secured. B) Physician□s orders were obtained for resident 68□s NJ Exec Order 26.4b1 . C) Resident 21□s NJ Exec Order 26.4b1 was properly positioned in a NJ Exec Order 26.4b1 and properly secured. 2. A) All residents utilizing urinary drainage bags were checked by the ADON and DON to ensure the drainage bags were properly positioned and properly secured. B) The ADON and DON conducted chart reviews to ensure each resident with an indwelling foley catheter had proper physician orders and the order reflected the correct catheter size for each resident. C) The ADON and DON reviewed the Treatment Administration Records for all residents utilizing indwelling foley catheters to identify missing/blank documentation.	

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 01/07/2025

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
F 690	Continued From page 22 NJ Exec Order 26.4b1 [redacted] A review of Resident # 68's Electronical Medical Record (EMR) did not reveal any physician orders related to an NJ Exec Order 26.4b1. During an interview on 01/02/2025 at 10:20 AM with surveyor #1, the US FOIA (b)(6) nurse said that NJ Exec Order 26.4b1 should always be kept in a NJ Exec Order 26.4b1 and off the floor. During an interview on 01/03/2025 at 10:40 AM with surveyor #1, the Licensed practical Nurse #1(LPN) said that when a resident has an NJ Exec Order 26.4b1 there should be orders in the computer with the size of the NJ Exec Order 26.4b1 to monitor the NJ Exec Order 2 and to NJ Exec Order 26. the NJ Exec Order 26.4b1 as needed. When asked if Resident #68 had orders the LPN looked in the computer and said, "no but he/she should." During an interview on 01/03/2024 with surveyor #1, the US FOIA (b)(6)) said there should have been an order place in the EMR when he/she returned to the facility. A review of a facility policy title "Care of Urinary Leg Bags and Bedside Drainage Bags" revealed under "Procedure" that, "6. Urinary drainage bags will be maintained below the level of the bladder in a privacy bag." A review of a facility policy titled "Physician's orders" revealed under, "Procedure" that, "1. All residents admitted to this facility shall be	F 690	3. A) The Foley Catheter Insertion policy was reviewed by the DON. The licensed nursing staff were re-educated on the facility□s Foley Catheter Insertion policy by the ADON. B) The Documentation Guidelines policy was reviewed by the DON. The licensed nursing staff were re-educated on the facility□s Documentation Guidelines policy by the ADON. C) The Care of Urinary Leg Bags and Bedside Drainage policy was reviewed by the DON. The nursing staff was re-educated on the facility□s Care of Urinary Leg Bags and Bedside Drainage Bags policy by the ADON. D) The Physician□s Order policy was reviewed by the DON. The licensed nursing staff were re-educated on the facility□s Physician□s Orders policy by the ADON. E) The IP will conduct daily infection control rounds throughout the facility to ensure the facility□s infection control policies are being followed. Any issues found will be addressed immediately and then reported to the management at the daily morning meeting. F) The DON/designee will conduct 3 random audits weekly to ensure	

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 01/07/2025

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
F 690	Continued From page 23 accompanied by physician's order adequate to provide immediate and essential care to the resident consistent with the resident's mental and physical status on admission. 2. If the physician's orders were not previously received and did not arrive with the resident, notify the physician, and obtain orders vial telephone within the admitting shift." N.J.A.C. 8:39-19.4(a) 2.) During the initial tour of the unit on 12/30/2024 at 09:44 AM, Resident #21 was observed in bed with a NJ Exec Order 26.4b1 laying on top of the bed with NJ Exec Order 26.4b1, and visible from the hallway. It was not secured to the bed frame. On 12/31/2024 at 9:31 AM Resident #21 was observed in their NJ Exec Order 26.4b1 wheelchair in their room. Resident #21's NJ Exec Order 26.4b1 bag was observed in the NJ Exec Order 26.4b1, but not secured to the wheelchair via the NJ Exec Order 26.4 which resulted in the NJ Exec Order 26.4b1 being collapsed upon itself. The surveyor reviewed the medical record for Resident #21. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Exec Order 26.4b1	F 690	a) residents using indwelling foley catheters are in place and correct. b) The documentation of foley catheter output is being completed per policy. c) Foley catheter bags in use are positioned below the level of the bladder, positioned properly and secured properly within a privacy bag. The audits will be conducted for a minimum of 6 months. Any issues found by the DON/designee will be addressed immediately. 4. The DON/designee will report and review all audit findings with the QAPI committee quarterly for a minimum of 6 months.	

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 01/07/2025

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
F 690	Continued From page 24 A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's [redacted] was [redacted] A review of the resident's individual comprehensive care plan (ICCP) included a focus area, revised on [redacted], that the resident "[had] an [redacted]: [redacted]". Interventions included: The resident [had] #16 [redacted]. [redacted] and [redacted] the [redacted] of the [redacted] [...]. A review of the Order Summary Report (OSR), dated as of [redacted] included the following physician orders (PO): A PO, dated [redacted] for [redacted] r with [redacted] to [redacted] for [redacted] Document [redacted] every shift for [redacted] A review of Resident # 21's [redacted] Treatment Administration Record (TAR) revealed the below 4 blanks for the order to document output every shift or [redacted]: [redacted] Day Shift [redacted] Evening Shift [redacted] Night Shift [redacted] Night Shift On 1/3/2025 at 10:24 AM, surveyor #2 interviewed CNA #2 who confirmed that [redacted] are to be to [redacted] the	F 690		

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 01/07/2025

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
F 690	Continued From page 25 NJ Exec Order 26.4 for infection control, secured via provided clip, and in a NJ Exec Order 26.4b1. When asked who is responsible for emptying, CNA #2 stated that they will empty the NJ Exec O and inform the nurse who will document the NJ Exec Order 26 On 1/3/2025 at 11:50 AM, surveyor #2 interviewed Licensed Nurse Practitioner (LPN #2) who confirmed that Resident #21 had an NJ Exec Order 26.4b1. LPN #2 described NJ Exec Order 26.4b1 included maintaining the NJ Exec O below the NJ Exec Orde of the NJ Exec Order 26.4 to prevent NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 of NJ Exec Orde into the NJ Exec Order 26.4b LPN #2 further explained that the NJ Exec Order 26.4b1 are to be NJ Exec Order 26.4b by the CNAs and reported to the nurses to document in the TAR. Upon reviewing Resident #21's electronic medical record, LPN #2 confirmed that there should not be any NJ Exec Order 26.4b1 on the TAR, the care plan incorrectly identified the resident NJ Exec Order 26 On 1/06/2025 at 11:44 AM during an interview with another surveyor, the US FOIA (b)(6) confirmed that NJ Exec Order 26.4b1 are to be secured NJ Exec Order the NJ Exec Orde of the NJ Exec Order 26.4 to encourage NJ Exec Order 26.4b1 and prevent NJ Exec Order 26.4b1 into the NJ Exec Order 26.4b When asked if the NJ Exec O should be left on the resident's bed, the US FOIA (b)(denied. On 1/7/2025 at 8:35 AM, surveyor #2 interviewed the US FOIA (b)(6)) who identified that NJ Exec Order 26.4b1 are to be NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 and secured to the bed with the provided bed clips. When asked why the devices are to be NJ Exec Order 26.4b1 the US Fo	F 690		

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 01/07/2025

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
F 690	Continued From page 26 responded, to prevent any [redacted] to the [redacted]. When asked why the [redacted] device to is be [redacted] with the [redacted] the [redacted] further explained that it is to [redacted] in place in an [redacted]. A review of a facility policy title "Catheter, Foley-Insertion", dated 10/20/17, revealed under "Procedure": 1. Check physician order. Must include [...] and instruction to record output every shift [...]. A review of a facility policy title "Care of Urinary Leg Bags and Bedside Drainage Bags", dated 10/15/17, revealed under "Procedure": 13. The urinary drainage bag/leg bag shall be emptied at the end of each shift or sooner if needed by the CNA. Document the amount of urine emptied; 6. Urinary drainage bags will be maintained below the level of the bladder in a privacy bag. N.J.A.C. 8:39-27.1 (a)	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents it was	F 695	1. A) Resident 236□s [redacted] was connected to the [redacted] bottle.	2/10/25

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 01/07/2025

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
F 695	Continued From page 27 determined that the facility failed to provide NJ Exec Order 26.4b1 care needs for the provision of NJ Exec Order 26.4b1 care in accordance with professional standards of practice specifically by leaving NJ Exec Order 26.4b1, exposed, open to air. The deficient practice was identified for 3 of 4 residents (Residents # 236, 29, 69) reviewed for NJ Exec Order 26.4b1 Care. The deficient practice was evidenced by the following: On 12/30/2024 at 10:30 AM during the initial tour of the facility, Surveyor # 1 observed Resident # 236 in bed. At that time, Resident # 236 was wearing a NJ Exec Order 26.4b1). Upon further observation, it was determined that the NJ Exec Orde was not connected to the NJ Exec Order 26.4b1 bottle located on the NJ Exec Order 26.4b1 and instead directly connected to the NJ Exec Order 26.4b1 itself. At that time, Surveyor # 1 also observed a NJ Exec Order 26.4b1 on top the night stand partially covered by a red towel. The NJ Exec Order 26.4b1 was not inside a container or bag exposing it to air. A review of Resident # 236's Electronic Medical Record (EMR) revealed under "Orders" that Resident # 236 was to received NJ Exec Order 26 at NJ Exec O through a NJ Exec Order 26.4b1 every shift for NJ Exec Order 26.4b1. There was also an order for NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 via NJ Exec Order 26.4b1 every four hours as needed for NJ Exec Order 26.4b1. A review of Resident # 236's EMR revealed he/she had a diagnosis of but not limited to	F 695	B) Resident 236□s NJ Exec Order 26.4b1 was replaced, dated and placed into a bag. C) Resident 29□s NJ Exec Order 26.4b1 was replaced, dated and placed into a bag. D) Resident 29□s NJ Exec Order 26.4b1 was replaced and dated. E) Resident 69□s NJ Exec Order 26.4b1 was replaced, dated and placed into a bag. 2. A) The dates of all residents□ oxygen and nebulizer mask/tubing were checked and replaced as needed by the ADON. B) All residents□ oxygen and nebulizer mask/tubing not in use were placed in bags by the ADON. 3. A) The facility□s Oxygen Administration Policy was reviewed by the DON. The ADON re-educated the licensed nursing staff on the facility□s Oxygen Administration Policy including respiratory tubing storage. B) The IP will conduct daily infection control rounds to ensure the facility□s infection control policies are being followed. Any issue found will be	

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 01/07/2025

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
F 695	Continued From page 28 NJ Exec Order 26.4b1 [redacted] On 1/06/2025 at 11:44 AM during an interview with Surveyor # 1, the US FOIA (b)(6) said NJ Exec Order 26.4b1 equipment should be stored in a zip-locked bag when not in use. She said, "infection control" as the reason. A review of the undated facility policy titled, "Oxygen Administration" revealed that, "There are multiple State and Federal codes that address the storage, handling and administration of oxygen. Procedures must be strictly adhered to in order to assure compliance with these codes." 2. On 12/30/2024 at 09:37 AM during initial tour, surveyor #2 observed Resident # 29's NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted] not labeled and left open to air sitting on the windowsill. On 01/03/2025 at 08:45 AM surveyor #2 observed the NJ Exec Order 26.4b1 [redacted] had not been changed and was dated NJ Exec Order 26.4b1 According to the Admission Record, Resident #29 was admitted to the facility with diagnoses including but not limited to; NJ Exec Order 26.4b1 [redacted]	F 695	addressed immediately and then reported to management at the daily morning meeting. C) The ADON/designee will conduct 3 random audits weekly to ensure all respiratory tubing is properly dated and stored when not in use per facility policy for a minimum of 6 months. 4. The ADON/designee will report and review all audit findings with the QAPI committee quarterly for a minimum of 6 months.	

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 01/07/2025

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
F 695	Continued From page 29	F 695		

A review of the Order Summary Report for resident # 29, revealed physician orders to [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] every night shift on every Wednesday.

During an interview on 01/02/2025 at 10:20 AM with surveyor #2, the [US FOIA (b)(6)] said that [NJ Exec Order 26] and [NJ Exec Order 26.4b1] should be labeled, dated, and changed weekly. The [US F] also said that all [NJ Exec Order] should be kept in a labeled bag when not in use, not left open to air.

A review of the facility policy titled, " Oxygen Administration" revealed under "Policy" that, "All safety precautions and care of equipment shall be performed according to recommended State and Federal guidelines and facility procedures.
3. On 12/31/2024 at 10:15 AM in Room #27, upon initial tour of the facility, surveyor #3 observed an oxygen cylinder secured inside a cylinder cart. Resting on top of the oxygen cylinder was a nebulizer mask that was unbagged and exposed to air. The nebulizer tubing was not dated.

The surveyor reviewed the medical record for Resident #69.

A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: [NJ Exec Order 26.4b1]).

A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the

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 01/07/2025

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
F 695	Continued From page 30 management of care, dated NJ Exec Order 26.4b1 included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, which indicated the resident's NJ Exec Order 26.4b1 was NJ Exec Order A review of the Order Summary Report (OSR), dated as of NJ Exec Order 26.4b1, included the following physician orders (PO): A PO, dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 vial NJ Exec Order orally four times a day for NJ Exec Order 26 On 1/3/2025 at 10:24 AM, surveyor #3 interviewed CNA #2 who confirmed that NJ Exec Order 26 supplies and NJ Exec Order 26.4b1 supplies were to be in a bag when not in use. On 1/3/2025 at 11:50 AM, surveyor #3 interviewed Licensed Nurse Practitioner (LPN #1) who stated that NJ Exec Order 26.4b1 were to be stored in a bag and dated when not in use. On 1/06/2025 at 11:44 AM during an interview with Surveyor # 1, the US FOIA (b) confirmed that NJ Exec Order 26.4b1 masks should be stored in a zip-locked bag when not in use for infection control reasons. A review of the facility's undated "Oxygen Administration" Policy included: All safety precautions and care of equipment shall be performed according to the recommended State and Federal guidelines and facility procedure.	F 695		
F 812 SS=F	N.J.A.C. 8:39-27.1 (a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		2/20/25

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 01/07/2025

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
F 812	Continued From page 31 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 12/30/2024 from 9:25 AM to 10:07 AM, the surveyor, accompanied by the US FOIA (b) and later at 10:07 AM joined by the US FOIA (b)(6) observed the following: 1.) In the refrigerator known as the "Drink Refrigerator," there was a tray that contained 35 bowls of butterscotch pudding, along with a tray	F 812	F812 " 1) " " 1-The refrigerator known as the Drink Refrigerator□□ the 35 bowls of butterscotch pudding, along with the 7 cups of applesauce and 1 cup of cottage cheese were labeled with the preparation date and anything not used was discarded. 2-In the dry storage area, open 4lb container of peanut butter, was given an open date and a used by date. " One Loaf of raisin bread received on 12/20/24 was discarded immediately. " 3-In the storage refrigerator the 45 ounces of container of butter with no open date was given an open date.	

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 01/07/2025

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
F 812	Continued From page 32 holding 7 cups of applesauce and 1 cup of cottage cheese. None of these items were labeled with preparation or use-by dates. The cook said that all the items should be labeled with both dates to ensure freshness and uphold food safety standards. 2.) In the dry storage area, there was an open 4-pound container of peanut butter that lacked both an open date and a use-by date. 1 loaf of raisin bread was labeled with a received date of 12/20/2024. The US FOIA (b)(6)) said that the peanut butter should be labeled with appropriate dates to ensure freshness and food safety. The US FOIA also mentioned that bread has a 5-day expiration period after receipt, and any expired bread should be discarded as it is no longer fresh. 3.) In the refrigerator known as the "Storage Refrigerator," there was an open 45-ounce container of butter with no open date, a half hotel pan of macaroni noodles labeled with a prepared date of 12/24/2024 with no use-by date, a half hotel pan of sautéed onions with a prepared date of 12/20/2024 and no use-by date, and a half hotel pan of meatballs with a prepared date of 12/17/2024 and no use-by date. The US FOIA (b)(6) said that all items should be properly labeled to ensure freshness and food safety. On 01/03/2025 at 9:26 AM, the surveyor observed inside of the nourishment refrigerator and freezer located on the first floor behind the nursing station an open half-pint milk carton with spillage in the plastic tray. The nourishment freezer had a buildup of freezer frost (ice buildup in the freezer) and contained brown debris, as	F 812	" The half pan of macaroni noodles labeled with a prep date of 12/24/2024 was discarded immediately. " The half pan of sauteed onions labeled with prep date of 12/20/24 was discarded immediately. " The half pan of meatballs labeled with prep date of 12/17/24 was discarded immediately. " All items in the nourishment refrigerator freezer located on the first floor was discarded and refrigerator was cleaned immediately. " 2) " All refrigerator and freezer were checked for appropriate labeling and discarded as needed. Any open items were immediately discarded. All refrigerator were cleaned and sanitized. The facility respectfully states that no residents were affected, however, all residents have the potential to be affected by this deficient practice. " 3) " The policy was reviewed and housekeeping and dietary staff were re-educated by the Food Service Director " Dietary staff have been assigned designated refrigerator/ freezer to discard outdated food items. " Dietary staff have been assigned designated refrigerator/freezer to check prep date and end date and discard as needed. " Weekly audits will be done by food service director/designee on all refrigerator and freezer in the kitchen and on each unit for 6 months.	

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 01/07/2025

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
F 812	Continued From page 33 well as a food item in a plastic bag dated 10/25/2024, which could not be identified. On 12/30/2024 at 10:40 AM, during an interview with the surveyor, the US FOIA (b)(6) said that nursing staff on the units are responsible for overseeing the pantries and nourishment refrigerators. On 01/03/2025 at 9:30 AM, during an interview with the surveyor, the US FOIA (b)(6) said that housekeeping is responsible for maintaining the cleanliness of the nourishment refrigerators on the units, while the dietary staff ensures that the food inside is not expired. On 01/07/2025 at 10:45 AM, during an interview with the surveyor, the US FOIA (b)(6) said that housekeeping is responsible for cleaning both the pantries and refrigerators on the nursing units. The US FOIA (b) also mentioned that keeping the refrigerator clean is essential for maintaining sanitation and preventing illness. On 01/07/2025 at 11:19 AM, during an interview with the surveyor, the US FOIA (b)(6)) said that dietary staff is responsible for checking expiration dates on food items in both the pantries and refrigerators on the nursing units to ensure freshness, while housekeeping is tasked with maintaining the cleanliness of the refrigerators. A review of the dated facility policy 01/01/2024, titled, "Labeling and Dating Policy", revealed, "If there is no printed manufactures date on product follow below dating protocol. Day 1 is first day labeling. Fresh breads, rolls, Danish, muffins 7 days. Portioned items 3 days. Leftovers (cooked,	F 812	" " 4) " The food service director/designee will report all findings to the quarterly QAPI committee for 6 months. " 5) Food Service Director/designee. - Date of completion 02/20/25	

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 01/07/2025

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
F 812	Continued From page 34 RTE) 3 days in cooler." A review of the undated facility policy titled, "Handling of Food Bought in by Visitors for Residents", revealed under Policy, "All food will be discarded after 48 hours or per the noted manufacturer expiration date." A review of the undated facility policy titled, "Cleaning and Maintenance of Nourishment Refrigerators", revealed under Procedures number 4 Cleaning and Maintenance, "Housekeeping staff will inspect the refrigerators on a daily basis and clean as needed, ensuring they are maintained to the highest hygiene standards."	F 812		
F 880 SS=D	N.J.A.C 8:39-17.2 (g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		2/10/25

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 01/07/2025

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
F 880	Continued From page 35 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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 01/07/2025

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
F 880	Continued From page 36 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide a sanitary and comfortable environment regarding NJ Exec Order 26.4b1 that helped prevent the development and transmission of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 The deficient practice was identified on 1 of 2 floors within the facility. The deficient practice was evidenced by the following: 1.) On 12/30/2024 at 9:44 AM, upon initial tour of the NJ Exec Order 26.4b1 unit, surveyor #1 observed Room NJ Exec with an NJ Exec Order 26.4b1 on the door. Surveyor #1 put on personal protective equipment (PPE) including gloves and gown to enter the room. Surveyor #1 interviewed the two residents inside the room. Prior to exiting the room, surveyor #1took off the PPE but was unable to locate a designated PPE trash can. On the same date at 9:51 AM, surveyor #1 interviewed Certified Nursing Assistant (CNA #1) who confirmed that there was not a designated trash bin in the room for used PPE. CNA #1 further advised that upon exiting a room, used	F 880	1. A) A receptacle to discard used PPE was placed in room NJ Exec B) The treatment cart was removed from resident 10□s room and sanitized. 2. A) The facility□s 3 other treatment carts were accounted for to ensure they were not being utilized inside resident rooms. B) All resident rooms requiring PPE receptacles were checked to ensure receptacles were in place by the IP. 3. A) The HS FOA who brought the treatment cart into resident 10□s room was educated by the IP on infection control practices, including which equipment is allowed to be brought into resident rooms and which equipment is not allowed to be brought into resident rooms. B) The licensed facility nursing staff was re-educated by the IP on infection control practices, including which equipment is allowed to be brought into resident rooms and which equipment is not allowed to be	

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 01/07/2025

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
F 880	Continued From page 37 PPE should be discarded in a designated PPE bin. CNA #1 put gloves on and took surveyor #1's used PPE from them, placed in trash bag, and discarded in soiled utility room. On 1/3/2025 at 10:24 AM, surveyor #1 interviewed CNA #2 who confirmed that used PPE should be removed in the resident room and discarded in designated trash bin. On 1/3/2025 at 11:50 AM, surveyor #1 interviewed Licensed Nurse Practitioner (LPN #1) who confirmed that prior to exiting an NJ Exec Order 26.4b1 [redacted] PPE should be removed and thrown away in a NJ Exec Order 26.4b garbage can. On 1/7/2025 at 8:35 AM, surveyor #1 interviewed the US FOIA (b)(6) [redacted]) who stated that NJ Exec Order 26.4b1 [redacted] included gown, gloves, and shield/mask depending on the task. Upon exiting the room, the US FO confirmed that used PPE should be disposed in a separate and designated trash bin in the resident room. A review of the facility's undated "Personal Protective Equipment" policy, included: soiled gowns, aprons, and lab coats must be removed prior to leaving the work area and discarded into the appropriate receptacle in the work area. B.) On 12/31/2024 at 9:55 AM, Surveyor #2 observed Registered Nurse (RN) #1 pushing the NJ Exec Order 26.4b1 [redacted] treatment cart into the bedroom of Resident #10. At that time, Surveyor #2 noted a sign on the room door indicating that Resident #10 was on NJ Exec Order 26.4b1 [redacted] for a NJ Exec Order 26.4b1 [redacted]	F 880	brought into resident rooms. C) The licensed nursing staff was re-educated by the IP on the procedure for discarding used PPE and the need for a specific receptacle to be in place inside of the resident room to discard used PPE. D) The IP will conduct daily infection control rounds throughout the facility to ensure the facility□s infection control policies are being followed. Any issues found will be addressed immediately and then reported to the management at the daily morning meeting. E) The DON/designee will conduct 3 random audits per week to ensure isolation and/or rooms with barrier precautions have all required equipment including receptacles in place and only proper equipment is being brought into resident rooms for a minimum of 6 months. 4. The DON/designee will report and review all audit findings with the QAPI committee quarterly for a minimum of 6 months.	

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 01/07/2025

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
F 880	Continued From page 38 A review of Resident #10's physician's orders located in the Electronic Medical Record revealed he/she had an order to maintain NJ Exec Order 26.4b1 [redacted] A review of the physician notes from NJ Exec Order 26.4b1 revealed that Resident #10 had a [redacted] on the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 as well as a NJ Exec Order 26.4b1 [redacted] On 12/31/2024 at 9:56 AM, during an interview with Surveyor #2, RN # 1 said that facility staff typically brings the treatment cart into the room for her to complete Resident #10 NJ Exec Order 26.4b1. When Surveyor #2 asked RN #1 if the treatment cart should have been inside the room of Resident #10, who is on NJ Exec Order 26.4b1 [redacted] for an [redacted] RN #1 said that she was not sure. On 12/31/2024 at 10:17 AM, during an interview with Surveyor #2, the US FOIA (b)(6) [redacted] said that the treatment carts should not be in residents room on NJ Exec Order 26.4b1 [redacted]. On 01/07/2025 at 8:35 AM, during an interview with Surveyor #1, the [redacted] confirmed that [redacted] are to be implemented for any resident with [redacted] A review of a facility policy dated 01/09/2024 titled, "MDROS", revealed, "Enhanced Barrier Precautions (EBP), which involves residents known to be colonized or infected with an MDRO, as well as those at increased risk due to factors like open wounds or indwelling medical devices;	F 880		

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 01/07/2025

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
F 880	Continued From page 39 this strategy aims to significantly reduce the transmission of MDROs within the facility. The Centers for Disease Control and Prevention (CDC) actively promotes the use of EBP in long-term care facilities to prevent MDRO spread. N.J.A.C. § 8:39-19.4(a)	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F 883		2/10/25

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 01/07/2025

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
F 883	Continued From page 40 must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to ensure documentation in the resident's medical record of the information provided regarding the benefits and risks of NJ Exec Order 26.4b1 and the administration or the NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 specifically the NJ Exec Order 26.4b1). The deficient practice was identified for 2 of 5 resident's reviewed for NJ Exec Order 26.4b1 (Resident #34 and Resident # 68). This deficient practice was evidenced by the	F 883	1. A) The NJ Exec Order 26.4b1 was administered to resident 34. B) The NJ Exec Order 26.4b1 was administered to resident 68. 2. The DON and ADON reviewed all current resident charts to ensure all residents received the Influenza vaccine or had a declination and appropriate education documented.	

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 01/07/2025

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
F 883	Continued From page 41 following: 1. According to the Admission Record, Resident #34 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted]. A Review of Resident #34's admission Minimum Data Set (MDS) an assessment tool used to facilitate care, dated NJ Exec Order 26.4b1 revealed a Brief Interview for Mental status score of [redacted]/15, indicating Resident #34 was NJ Exec Order 26.4b1 [redacted] Section 'NJ Exec Order' indicated Resident #34's NJ Exec Order 26.4b1 was not received. The MDS further revealed that there was no reason the NJ Exec Order 26.4 was not given. 2. According to the Admission Record, Resident #68 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted]). A Review of Resident #68's admission Minimum Data Set (MDS) an assessment tool used to facilitate care, dated NJ Exec Order 26.4b1 revealed a Brief Interview for Mental status score of [redacted]/15, indicating Resident #68 had NJ Exec Order 26.4b1 [redacted] Section 'NJ Exec Order' indicated Resident #68's NJ Exec Order 26.4b1 was not received. The MDS further revealed that there was no reason the NJ Exec Order 26.4 was not given.	F 883	3. A) The DON reviewed the facility□s Resident Influenza Program policy. The DON re-educated the facility□s [redacted] on the facility's Resident Influenza Program policy. B) The immunization status of all new admissions/readmissions will be reviewed by DON daily and reported to the management team at the morning report. C) The DON/designee will conduct 3 random audits weekly to ensure each resident has received mandatory vaccinations or a declination and appropriate documentation is in place for a minimum of 6 months. 4. The DON/designee will report and review all audit findings with the QAPI committee quarterly for a minimum of 6 months.	

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 01/07/2025

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
F 883	Continued From page 42 During an interview on NJ Exec Order 26.4b1 at 11:05 AM with the surveyor, the US FOIA (b)(6) said that she had missed both residents' NJ Exec Order 26.4b1. The US FO said they were given on NJ Exec Order 26.4b1, however they should have been given by end of NJ Exec Order 26.4b1 A review of an undated facility provided policy titled "Resident Influenza Program", revealed under "Procedure" that. "1. The Influenza Vaccine will be offered annually to all residents at [Facility's name], October through March 31st, unless the immunization is medically contraindicated, or the resident has already been immunized during the time period." N.J.A.C. 8:39-19.4 (h)	F 883		
F 919 SS=F	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/30/2025 in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that the resident call bell system was properly functioning by notification of an activation when pressing the call bell button. This deficient	F 919	F919 Immediate The nurse call cord was replaced for the defective device. Others The facility checked all other nurse call cords and found no other calls	2/20/25

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 01/07/2025

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
F 919	Continued From page 43 practice had the potential to affect all residents and was evidenced by the following: An observation at 12:22 PM revealed that the call bell system did not notify staff of a call bell system activation by visual and or audible notification for bed 1 in room 229 when the US FOIA (b)(6) pressed the call bell button. In an interview at the time, the US FOIA (b)(6) confirmed that the call bell system light did not activate outside of the room and that notification at the nurse's station was not received. The US FOIA (b)(6) stated that the call bell button needed to be replaced, and they would make sure it was correct. N.J.A.C 8:39-31.2(e)	F 919	nonoperational. All residents have the potential to be affected by this deficient practice. Systemic changes The facility reviewed the policy for nurse call testing and will add daily checks by nursing. All staff involved with nurse call were in-serviced by the maintenance director on the importance of reporting non -operational nurse call. Maintenance director will complete a monthly audit to test the house call systems. QAPI All findings will be reported to the QAPI committee for 6month. Maintenance Director 02/20/25	

New Jersey Department of Health

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 01/07/2025

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 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ00177022 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for 16 of 21 day shifts as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for the following weeks as follows: 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	S 560	1. Additional contract were signed with nursing staffing agencies to obtain additional certified nursing assistants. 2. All residents could be affected. 3. A) The staffing ratios will be monitored by the staffing coordinator, HR Director and the DON/designee on a per shift basis. B) The facility will maintain current contracts with nursing staffing agencies and continue to seek out additional contracts.	2/28/25

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

Electronically Signed | 01/24/25

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 01/07/2025

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 1 Governor signed into law P.L. 2020 c 112, 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 Certified Nurse Aide (CNA) to every eight residents for the day shift. One 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 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. 1. For the week of Complaint staffing from 09/08/2024 to 09/14/2024, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -09/08/24 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs. -09/09/24 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs. -09/10/24 had 7 CNAs for 90 residents on the day shift, required at least 11 CNAs. -09/11/24 had 7 CNAs for 90 residents on the day shift, required at least 11 CNAs. -09/13/24 had 7 CNAs for 90 residents on the day shift, required at least 11 CNAs. -09/14/24 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs.	S 560	C) The facility will continue efforts to procure permanent certified nursing assistants via increased recruitment efforts, attempts to align directly with a certified nursing assistant training center, sign on bonuses, increased retention efforts, staff bonuses and overtime. 4. The staffing ratio result findings will be reviewed and reported by the DON/designee at the quarterly QAPI meeting for a minimum of 6 months.	

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 01/07/2025

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 2 2. For the 2 weeks of staffing prior to survey from 12/15/2024 to 12/28/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -12/15/24 had 7 CNAs for 82 residents on the day shift, required at least 10 CNAs. -12/16/24 had 8 CNAs for 81 residents on the day shift, required at least 10 CNAs. -12/17/24 had 9 CNAs for 81 residents on the day shift, required at least 10 CNAs. -12/18/24 had 8 CNAs for 81 residents on the day shift, required at least 10 CNAs. -12/19/24 had 9 CNAs for 81 residents on the day shift, required at least 10 CNAs. -12/20/24 had 8 CNAs for 80 residents on the day shift, required at least 10 CNAs. -12/21/24 had 9 CNAs for 79 residents on the day shift, required at least 10 CNAs. -12/22/24 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs. -12/27/24 had 7 CNAs for 75 residents on the day shift, required at least 9 CNAs. -12/28/24 had 8 CNAs for 75 residents on the day shift, required at least 9 CNAs. During an interview on 01/07/2025 at 08:28 AM with the surveyor, the staffing coordinator and Assistant Director of Nursing said they try to match the state regulations for CAN staffing. They also said they offer bonuses, incentives, and gift cards to encourage staffing. A review of an undated facility provided policy titled "Staffing Policy" revealed under, "Procedure" that, "1. Staffing Ratios: We strive to adhere to the minimum staffing rations required by New Jersey state regulations, as outlined by	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 01/07/2025

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 3 the department of Health, and federal guidelines established by CMS. Staffing levels are reviewed regularly and adjusted based on the residents' needs, with additional coverage provided during peak times or emergencies to maintain quality care.	S 560		
S2114	8:39-31.1(a) Mandatory Physical Environment No construction, renovation or addition shall be undertaken without first obtaining approval from the Department, Division of Certificate of Need and Licensing and/or the Department of Community Affairs, Health Care Plan Review Unit. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews between 12/30/2024 and 1/03/2025 it was determined that the facility failed to obtain the necessary approvals from the Department, Division of Certificate of Need and Licensing, and/or the Department of Community Affairs, Health Care Plan Review Unit before proceeding with any construction, renovation, or addition. An observation on 12/30/2024 revealed, renovations of the entire building have been underway. New wallpaper, painting, fixtures, and flooring were noticed throughout the facility. The main entrance/front lobby area was closed at the time of survey due to renovations that were currently being worked on. Cases of leftover unused flooring tile were noticed propped up on the receptionist desk. The main entrance/exit was closed and a temporary main entrance/exit was being utilized.	S2114	S2114 Immediate The facility administration has issued a stop work and will not proceed with any additional renovation work. The facility shall submit the required CON to the department of health and the community affairs to document the items which were done to include all new wallpaper, painting, fixtures, and flooring that was noticed throughout the facility including the main entrance/front lobby area and attain the required approvals to continue to completion. Others The facility respectfully states that no were residents were directly involved however all had the potential to be affected by this deficient practice. Systemic Change	2/20/25

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 01/07/2025

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
S2114	Continued From page 4 In an interview on 12/30/2024 at 10:20 AM, the surveyor requested any documentation regarding the approval/submittal for approval, for the renovations that were currently being conducted. Documentation review on 01/03/2025 revealed, the documentation that was provided was for work that had not commenced. This included alterations to the rehab gym and for a new laundry room door. Documentation regarding approval/submittal for approval for the renovations of the main entrance/front lobby area or the library could not be provided. The facility's Administrator was informed of the deficient practice at the Life Safety Code exit conference on 1/03/24 at 12:30 PM. N.J.A.C 8:39-31.1(a), 8:39-31:2(e)	S2114	The facility has reviewed its policy and procedures for construction renovations to insure compliance with the requirements as stated in the NJDOH regulation8:39-31.1(a) Mandatory Physical Environment that no construction, renovation or addition shall be undertaken without first obtaining approval from the Department, Division of Certificate of Need and Licensing and/or the Department of Community Affairs, Health Care Plan Review Unit. All staff and contracted workers that are related to any construction or renovations will be in serviced regarding the policy by maintenance director. The administrator will initiate an initial audit and a quarterly audit of renovation/construction projects in the facility to ensure compliance and obtain a Certificate of Need as necessary. QAPI The results of the audit will be presented to the facility QAPI committee including any necessary corrective actions of the identified areas. Administrator/designee 02/20/25	
S2235	8:39-31.6(c) Mandatory Physical Environment Fire regulations and procedures shall be posted in each unit and/or department. A written evacuation diagram that includes evacuation procedures and locations of fire exits, alarm boxes, and fire extinguishers shall be posted conspicuously on a wall in each resident care unit and/or department throughout the facility.	S2235		2/10/25

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 01/07/2025

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
S2235	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 1/03/2025 in the presence of the Director of Maintenance (DOM), it was determined that the facility failed to ensure that a written evacuation diagram was posted on a wall in each resident care unit and/or department throughout the facility. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 01/03/2025 at 09:50 AM, revealed that an evacuation diagram was not provided on the first floor. In an interview at the time, the surveyor asked the DOM if there was an evacuation diagram posted anywhere on the first or second floor. The DOM confirmed that there were no posted evacuation diagrams and stated that during renovations all of the posted evacuation diagrams were removed and they have not been replaced yet. The facility's Administrator was informed of the deficient practice at the Life Safety Code exit conference on 1/03/24 at 12:30 PM. N.J.A.C 8:39-31.6 (c), 8:39-31:2(e)	S2235	S2235 Immediate The facility has contacted the design architect to provide new updated written evacuation diagrams that includes evacuation procedures and locations of fire exits, alarm boxes, and fire extinguishers that shall be posted conspicuously on a wall in each resident are unit and/or departments throughout the facility. Others The facility respectfully states that no residents were directly involved however all had the potential to be affected by this deficient practice. Systemic Changes The facility will add to all renovation project agreements the immediate restoration of all fire and emergency items upon the completion of work in any area. The Maintenance director shall audit all areas for proper emergency signage monthly to ensure all are legible and complete with a newly created audit log. Any items found not in complaint shall be scheduled for immediate replacement If immediate correction cannot be accomplished administration shall be notified.	

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 01/07/2025

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
S2235	Continued From page 6	S2235	QAPI The results of the QA audit shall be review at Quality assurance meetings monthly for six months and the reduced to semiannual if approved by the committee. Maintenance Director 02/20/25	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315437 Y1	A. Building B. Wing Y2	3/4/2025 Y3

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 F0690 Reg. # 483.25(e)(1)-(3) LSC	Correction Completed 02/10/2025	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	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 1/7/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315437 Y1	A. Building B. Wing Y2	3/4/2025 Y3

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 F0558	Correction	ID Prefix F0584	Correction	ID Prefix F0641	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(g)	Completed
LSC	02/10/2025	LSC	02/20/2025	LSC	02/10/2025
ID Prefix F0656	Correction	ID Prefix F0658	Correction	ID Prefix F0689	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	02/10/2025	LSC	02/10/2025	LSC	02/10/2025
ID Prefix F0690	Correction	ID Prefix F0695	Correction	ID Prefix F0812	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	02/10/2025	LSC	02/10/2025	LSC	02/20/2025
ID Prefix F0880	Correction	ID Prefix F0883	Correction	ID Prefix F0919	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(d)(1)(2)	Completed	Reg. # 483.90(g)(1)(2)	Completed
LSC	02/10/2025	LSC	02/10/2025	LSC	02/20/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/7/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061333 Y1	A. Building B. Wing Y2	3/4/2025 Y3

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 02/28/2025	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	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	
1/7/2025	☐ 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	3/4/2025 Y3

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 02/28/2025	ID Prefix S2114 Reg. # 8:39-31.1(a) LSC	Correction Completed 02/20/2025	ID Prefix S2235 Reg. # 8:39-31.6(c) LSC	Correction Completed 02/10/2025
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 1/7/2025	☐ 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 _____	**01/07/2025**

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 Laurel Bay Health and Rehab was in found to be in non-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		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.	E 037		3/3/25

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

Electronically Signed | 01/23/2025

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 _____	**01/07/2025**

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 037	Continued From page 1 *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.	E 037		

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 _____	**01/07/2025**

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 037	Continued From page 2 (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037		

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 _____	**01/07/2025**

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 037	Continued From page 3 *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		

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 _____	01/07/2025

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 037	Continued From page 4 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review, and interview on 12/31/2024 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to a) ensure initial training in emergency preparedness (EP) policies and procedures to all new staff and b) provide EP training at least annually. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 12/31/2024 at 10:15 AM revealed that annual EP training was last conducted on 06/07/2021. In an interview at the time, the US FOIA (b)(6) confirmed that annual training had not been conducted in 2024 and stated that going forward it would be included as a mandatory annual training for all	E 037	E037 EP training I. Immediate 1. All staff will be in-service on the emergency activation plan by the Director of Maintenance/designee 2. The emergency plan in-service education has been added to the mandatory in-service schedule for all staff on annual basis. 3. The emergency plan training package has been added to the new employee package and shall be completed prior to scheduling staff for work. II. Others. 1. The facility respectfully states that all persons in the facility were potentially affected by this deficiency however none were directly involved.	

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 _____	**01/07/2025**

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 037	Continued From page 5 staff. A record review on 12/31/2024 revealed initial EP training for new staff was not conducted upon hire. In an interview at the time, the [redacted] confirmed the record review and stated that going forward they would include EP training in the mandatory in-services for new hires. The facility's [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 1/3/25 at 12:30 PM. N.J.A.C 8:39-31.2(e)	E 037	III. Systemic Changes 1. The Administrator, in conjunction with the Director of Maintenance, Director of Nursing and Medical Director, reviewed and revised the facility emergency policies and procedures and incorporated the policies into the Comprehensive Emergency Preparedness Plan. 2. All facility staff will be in-service on the facility Emergency Preparedness Plan, including but not limited to: Facility and Community Risk Assessment Hazard Vulnerability Assessment Natural and Man-Made Disasters Missing Residents Cooperation and Collaboration with local, State and Federal Officials Communication with Staff, Residents, Volunteers During Time of Emergency Tracking of On-Duty Staff within or relocated outside facility during emergency Continued Care and Treatment of Residents at Alternate Sites During Emergency Situations Communication with Other Facilities, Staff and Local/State/Federal Emergency Management Agencies, including sharing of occupancy needs Staff and Volunteer Training and Training Materials Emergency Drills/Documented Critiques of Drills Community-Based Emergency Preparedness Exercise/Drill and Critique of Facility Performance 3. Lesson Plan and Attendance Records will be maintained for reference and validation.	

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 _____	**01/07/2025**

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 037	Continued From page 6	E 037	The Administrator, in conjunction with the Director of Maintenance, will conduct Emergency Preparedness Drills and/or Tabletop exercises with facility staff on all shifts within the next 3 months, then annually thereafter. Documentation of drills and critiques of staff performance will be maintained in the logbook for reference and validation. IV. QA Monitoring The Director of Maintenance will review the staff response to Emergency Preparedness Drills and Tabletop exercises and present findings to the QA Committee on a monthly basis for the next three months, for evaluation by the QA Committee. Drill response that reveals negative or incorrect response will be immediately reported to the Administrator and Director of Nursing for further action. The Director of Maintenance will present Community-based Emergency Preparedness Drill/Table-top Exercise to the QA Committee for evaluation. V. Responsible Person: Director of Maintenance/designee VI. 03/03/25	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the	E 041		2/20/25

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 _____	**01/07/2025**

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 041	Continued From page 7 policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems	E 041		

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 _____	**01/07/2025**

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 041	Continued From page 8 operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.	E 041		

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 _____	01/07/2025

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 041	Continued From page 9 (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on record review and interview on 12/31/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to obtain a letter from its natural gas vendor to demonstrate the fuel source was reliable and to meet the requirements for an on-site backup power source. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review revealed a letter of reliability from the natural gas fuel provider was not included in the EP plan. In an interview at the time, the US FOIA (b)(6) [redacted] confirmed the record review and stated that they contacted their natural gas vendor and was informed that they do not provide letters of reliability. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 1/3/25 at 12:30 PM. N.J.A.C 8:39-31.2(e)	E 041	E041 Emergency Power I. Immediate The facility engineer has contacted the local natural gas supplier NJ natural gas to provide the missing letter of continued gas supply. II. Others. The facility has only one generator for supply of EES power and therefore no other areas were affected. III. Systemic The facility shall annually request an update to the letter in conjunction with review of the emergency plan. This shall be added to the facilities annual calendar The facility shall maintain a contract for the emergency connection to a portable generator of enough size to meet facility EES requirements should there be an interruption of natural gas supply. Iv. QAPI The Quality assurance committee will review and accept the letter upon receipt and annually thereafter. Director of Maintenance 02/20/25	

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 _____	**01/07/2025**

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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations between 12/30/24 and 01/03/2025. Laurel Bay H&R 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 Occupancy. Laurel Bay H&R Center is a 2 story building that was built in 90's, It is composed of Type I fire Resistant construction. The facility is divided into 07 smoke zones. The generator powers approximately 40 % of the building. The facility has 1 elevator and 2 egress stairwells.	K 000		
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/30/2024 in the presence of the[US FOIA (b)(6)] [redacted], it was determined that the facility failed to ensure that Stairways and smokeproof enclosures used as exits were in accordance NFPA 101:2012 Edition, Sections 7.2,	K 225	K225 Immediate Corrections:¿ Maintenance staff evaluated and repaired the Egress doors as cited:¿ exit door 2rd floor stair by maintenance shop had a panic bar	2/20/25

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 _____	01/07/2025

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
K 225	Continued From page 11 7.2.1.6.2, 7.2.1.5.10, A.7.2.1.5.10, 19.2.2.3 and 19.2.2.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:30 PM revealed the exit stairway enclosure near the maintenance office was provided with a turn knob handle which would make it incapable of being operated with one hand and would require twisting of the wrist. An observation at 1:00 PM revealed the exit stairway enclosure on the second floor near room 201 was provided with a delayed egress locking arrangement. The access control keypad panel did not function when tested by the US FOIA (b)(6) Additionally, the door was provided a turn knob handle which would make it incapable of being operated with one hand and would require twisting of the wrist. In interviews at the time, the US FOIA (b)(6) confirmed the observations. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 1/3/25 at 12:30 PM. N.J.A.C 8:39-31:2(e) NFPA 70, 99, 110, 111	K 225	installed. 2nd floor door by room 201 had panic device installed. The magnetic locking keypad controlling device was reprogrammed and tested to be operational All involved doors were repaired to ensure¿the alarm activates and releases within when pushed as required without staff intervention.¿ II Identification of Other Residents:¿ The Facility respectfully states that¿all residents were potentially affected but¿no residents were involved in this deficiency¿ The Maintenance staff made full environment rounds to check all¿the¿Emergency Exit doors/Egress doors in the¿entire¿Facility to ensure a functional and compliant¿activated¿alarm per requirements¿with appropriate signage present There were no¿additional¿issues identified from this environment review, as all egress doors functioned appropriately¿ Systemic Changes:¿ The Maintenance staff reviewed the requirements for Egress Doors as per K225, to ensure our Preventive Maintenance Plan met these requirements. The Plan was found compliant All Housekeeping and Maintenance staff will be re-educated by Maintenance/Designee to ensure that the staff is aware of the requirements for egress requirements as per NFPA 101 (2012) 7.2, 18.2, And 119.2, and our Preventive Maintenance plan for ongoing compliance is fully	

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 _____	**01/07/2025**

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
K 225	Continued From page 12	K 225	implemented The Lesson Plan will concentrate on the following: Overview of K225 requirements Review of our Preventive maintenance plan Responsibility to perform Monthly Audits and inspections A copy of the Lesson Plan and attendance will be filed for reference and validation¿ ¿ QA¿Monitoring The Director of Maintenance has developed an Environment Rounds audit as part of our Preventive Maintenance Program. Audits will be conducted weekly by the Maintenance staff/designee and Egress doors will be checked¿for compliance for 6 months. Audits with negative findings will be referred to the Administrator for corrective actions as needed. Audits with negative findings will warrant contacting our Vendor to provide repairs and corrections as identified Audit findings and corrective actions will be presented to the QA Committee quarterly for evaluation and follow-up for 6 months. 1. Responsible Person: Director of Maintenance//Designee 2. Completion Date: 2/20/25	
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit	K 281		2/20/25

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 _____	01/07/2025

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
K 281	Continued From page 13 discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/30/2024 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure illumination of the means of egress was either continuously in operation or capable of automatic operation without manual intervention in accordance with NFPA 101: 2012 Edition, Sections 19.2.8 and 7.8. This deficient practice had the potential to affect all residents and was evidence by the following: An observation at 1:00 PM revealed, when the light switch on the second-floor exit access corridor was tested, all the lights in the exit access corridor turned off. This would prevent automatic operation of the emergency lighting in cases of emergency if the light switch were not in the on position at the time of an emergency. An observation at 1:05 PM revealed that when the light switch on the first-floor exit access corridor was tested, all the lights in the exit access corridor turned off. This would prevent automatic operation of the emergency lighting in cases of emergency if the light switch were not in the on position at the time of an emergency. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was notified of the deficient practice at the Life Safety Code exit	K 281	K281 Emergency Lighting Immediate Correction The facility electrician was contacted to correctly replace/restore the required emergency means of egress light operation continuous and on alternate power source in accordance with all applicable regulations. This was accomplished on both the first and second floor emergency egress corridors. Upon completion the lighting was tested and found to function as required. Identification of others The facility conducted a review of all other areas which require continuous illumination and found no other areas of concern. No residents were found to be affected by this with potential of all residents to be affected. Systemic changes The facility has reviewed and revised the policy for inspection and testing of the Essential Electrical System to include the required lighting as required by NFPA 110 and NFPA 101 The facility has included the required testing and inspection of the lighting for the transfer switch to the Monthly EES system inspection. The facility staff who perform the inspections shall be educated on the requirements and changes in policy and	

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	01/07/2025

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
K 281	Continued From page 14 conference on 01/03/2025 at 12:30 PM. N.J.A.C 8:39-31.2(e)	K 281	procedures. I. QA 1. The monthly test report of the lighting shall be recorded on the audit log and submitted for review to administration and the QA committee for review. for six months. Responsible Maintenance director 2/20/25	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/30/2024 and 1/03/2025 in the presence of the US FOIA (b)(6)), it was determined that the facility failed to ensure that ensure that exits were marked by an approved sign that is readily visible, and that a sign with directional indicator showing the direction of travel was provided in every location where the direction of travel to reach the nearest exit is not apparent in accordance with NFPA 101:2012 Edition, Sections 19.2.10.1, 7.10, and 7.10.1.2.1. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 12/30/2024 at 1:16 PM	K 293	K293 immediate The maintenance staff contacted the facility electrician to install an illuminated exit sign in the 1st floor corridor to show the proper direction of egress from the gym, laundry room and courtyards. The maintenance staff installed a new illuminated exit sign with directional chevron showing path of egress from the outdoor enclosed courtyards both large and small area on the 1st floor on. The maintenance staff permanently relocated the No Exit sign from the wall to the Patio door.	2/20/25

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 _____	**01/07/2025**

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
K 293	Continued From page 15 revealed the facility failed to provide an approved exit sign leading out of the large, enclosed courtyard. An observation at 1:17 PM revealed the facility failed to provide an approved exit sign leading out of the small, enclosed courtyard. In an interview at the time, the US FOIA (b)(6) confirmed the observation. An observation on 01/03/2025 at 9:47 AM revealed, when exiting the large enclosed courtyard, therapy gym and laundry room, a directional indicator showing the direction of travel to the nearest exit was not provided in the corridor. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 01/03/2025 at 12:30 PM. N.J.A.C 8:39-31.2(e)	K 293	identify other areas potentially affected The facility acknowledges that residents, staff, and visitors utilizing the area have the potential to be affected by this practice. The Director of Maintenance checked all corridors for proper exit signage. No other deficiencies were found. system measures to prevent reoccurrence Maintenance will inspect and replace exit signage monthly or as needed. The Director of Maintenance will monitor the completion of the work order. Exit signage inspections are part of ongoing monthly preventative maintenance cycles. To track this process, the preventive maintenance system has added an audit tool for staff to inspect exit signage monthly to ensure proper functioning, lettering, and visibility. The Director of Maintenance or Designee will inspect exit signage monthly and complete documentation in facility Records & Logs book as required. Director of Maintenance/designee will inservice staff on the requirements of the inspection. A copy of the lesson Plan and attendance will be filed for reference and validation monitoring corrective actions The Director of Maintenance will review the Records & Logs book for any cases of non-compliance. The Director of Maintenance submits the audit tool with all cases of non-compliance to QAPI committee for review and adjustments as may be required for 6 months.	

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 _____	**01/07/2025**

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
K 293	Continued From page 16	K 293	If there are no deficiencies found QAPI can recommend a reduced report to the semiannual then annually. The Director of Maintenance will report the findings quarterly to the Safety Committee for a period of 6 months, as well as a correction plan if warranted. I. Responsibility: Director of Maintenance Completion:02/20/25	
K 342 SS=F	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/30/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that the operable part of each manual fire alarm pull station was not less than 42-inches and not more that 48-inches above the floor level in accordance with NFPA 72:2010 edition, Section 17.14.4. This deficient practice had the potential to affect all residents	K 342	K342 Fire Alarm system I. Immediate: The facility director of Maintenance contacted the licensed fire alarm service company to have the following pull stations relocated to the proper operational height in NFPA 72 of 42- 48 inches: Manual pull station located near room	2/20/25

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 _____	01/07/2025

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
K 342	Continued From page 17 and was evidenced by the following: Observations between 12:22 PM and 1:39 PM revealed: 1. The operable part of the manual pull station near room 230 was 57-inches above the floor level. 2. The operable part of the manual pull station near room 3 was 62-inches above the floor level. 3. The operable part of the manual pull station outside of the enclosed courtyard area was 71-inches above the floor level. 4. The operable part of the manual pull station near room 31 was 67-inches above the floor level. 5. The operable part of the manual pull station near room 18 was 67-inches above the floor level. 6. The operable part of the manual pull station near the first-floor nurse's station was 67-inches above the floor level. In interviews at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 01/03/2025 at 12:30 PM. N.J.A.C 8:39-31.2(e) NFPA 10	K 342	230. Manual pull station located near room 3. Manual pull station located outside of the courtyard. Manual pull station located near room31. Manual pull station located near room18. Manual pull station located near first floor nurse station. Identification of others The facility conducted a review of all other areas and found no other areas of concern. No residents were found to be affected by this with potential of all residents to be affected. Systemic changes: 1. The facility has reviewed the fire testing and inspection policy and found no changes were needed, 2. The facility has reviewed the service contract with the licensed fire alarm company and included the requirements to provide system updates in order to maintain compliance with NFPA 72 3. An audit tool has been created to review the status of the fire alarm system to assure continued compliance. QAPI The Director of Maintenance will review the Records & Logs book for any cases of non-compliance. The Director of Maintenance submits the audit tool with all cases of non-compliance to QAPI committee for review and adjustments as may be required for 6 months. If there are no deficiencies found QAPI can recommend a reduced report to the semiannual then annually. The Director of Maintenance will report the findings quarterly to the Safety	

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 _____	01/07/2025

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
K 342	Continued From page 18	K 342	Committee for a period of 6 months, as well as a correction plan if warranted. Director of maintenance completion:02/20/25	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/30/2024 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that fire extinguisher where mounted and that mounting locations were conspicuously marked so that they are highly visible even from a distance in accordance with NFPA 101:2012 Edition, Sections 9.7.5 and NFPA 10:2010 Edition, Sections 6.1.3.1, 6.1.3.3.1, 6.1.3.3.2 and 6.1.3.8.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:30 PM revealed the fire extinguisher near room 230 was mounted at 4-inches above the ground but the mounting location was not marked so that it was highly visible from a distance. An observation at 12:50 PM revealed the fire extinguisher near room 230 was mounted at 4-inches above the ground but the mounting location was not marked so that it was highly	K 355	K355 Portable fire extinguisher Immediate: The director of maintenance installed the missing fire extinguisher signs over the wall mounted extinguishers so as to conspicuously mark fire extinguishers mounting locations and they are highly visible even from a distance. The fire extinguisher in the main entrance area was conspicuously mounted to the wall at the required height. Others: The Facility respectfully states that¿all residents were potentially affected but¿no residents were involved in this deficiency¿ The Maintenance staff made full environment rounds to check fire extinguishers with appropriate signage present There were no¿additional¿issues identified from this environment review, as all other extinguishers were identifiable	2/20/25

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 _____	01/07/2025

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
K 355	Continued From page 19 visible from a distance. An observation at 1:07 PM revealed the fire extinguisher at the temporary main entrance was not mounted. In interviews at the time, the [redacted] confirmed the observations. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 01/03/2025 at 12:30 PM. N.J.A.C 8:39-31.2(e) NFPA 10	K 355	Systemic changes: The facility reviewed and updated the monthly fire extinguisher policy to include the appropriate signage is in place. The staff assigned to perform the monthly inspection shall be in-serviced on this updated policy by the Director of Maintenance. 3. An audit tool shall be utilized to identify any areas of concern with immediate correction scheduled for any deficient findings. QAPI The Director of Maintenance will review the Records & Logs book for any cases of non-compliance. The Director of Maintenance submits the audit tool with all cases of non-compliance to QAPI committee for review and adjustments as may be required for 6 months. If there are no deficiencies found QAPI can recommend a reduced report to the semiannual then annually. Director of maintenance /designee Completion: 02/20/25	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors	K 363		2/20/25

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 _____	01/07/2025

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
K 363	Continued From page 20 to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/30/2024 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that doors in the corridor were: A) capable of being closed and maintained closed against the force of 5 lb applied at the latch edge of the door and B) able to resist the passage of smoke in accordance with NFPA 101:2012 Edition, Sections 19.3.6.3.2 and	K 363	K363 Corridor Doors I. Immediate Corrective Action¿ The doors to the resident sleeping room214 immediately made to latch by facility staff.¿ The door room 205 was adjusted in the frame to remove the ¿ inch gap at the top of the frame. The doors on the first and second floor day room double doors will be removed.	

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 _____	01/07/2025

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
K 363	Continued From page 21 19.3.6.3.5. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:05 PM revealed resident room 214 door did not latch when tested by the [redacted] An observation at 12:49 PM revealed resident room 205 contained a 1/4-inch space between the top of the door and the door frame. An observation at 12:53 PM revealed the dining room on the second floor contained a pair of swinging doors that were not provided with a means of keeping the door closed in the frame against the force of 5 lbs. An observation at 1:11 PM revealed the dining room on the first floor contained 2 separate doors that were not provided with a means of keeping the door closed in the frame against a force of 5 lbs. In interviews at the time, the [redacted] confirmed the observations. The facility's [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 1/03/25 at 12:30 PM. N.J.A.C 8:39-31.2(e)	K 363	II Identification of others¿ a. An audit has been conducted of all corridor doors throughout the facility to make sure all doors close and latch as required b. no additional doors were found noncompliant. c. All residents have the potential to be affected by this deficient practice, however no additional residents were found to be affected upon completion of this review.¿ III. Systemic Changes¿ The facility has reviewed the Preventive Maintenance Plan and door inspection policy and revised the same to include directives for Proper latching hardware, as well as inspection observations¿ All Maintenance staff will be educated by the maintenance director¿on the Preventive Maintenance Plan and requirement for appropriate Door operation¿ The Lesson Plan will concentrate on the following:¿ ¿> Overview of requirements for K363¿ > Preventive Maintenance plan for performing observational inspections¿of the doors¿ > Responsibility for providing appropriate door closures.¿ A copy of the Lesson Plan and attendance will be filed for reference and validation¿ The facility reviewed and revised its policy regarding corridor doors.¿ IV. QA monitoring¿ An audit tool was created to monitor the facility□s corridor doors.¿	

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 _____	**01/07/2025**

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
K 363	Continued From page 22	K 363	Monitoring of the facility□s doors will be performed monthly for the first 3 months and then quarterly thereafter for 9 months.¿ Any negative findings from inspections shall be reported to the administrator for further evaluation and will be addressed.¿ All reports shall be brought to the Quality Assurance meeting to review with the team to ensure that repairs are being performed in a timely manner for 12 months.¿¿ V. Title Responsible¿director maintenance /Designee Completion date: 02/20/25	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)	K 531		2/26/25

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 _____	01/07/2025

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
K 531	Continued From page 23 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 12/30/2025 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that elevators were inspected and tested in accordance with NFPA 101:2012 Edition, Sections 19.5.3, 9.4.2,9.4.3 and ASME A 17.1, and A 17.3. This deficient practice had the potential to affect all residents and is evidenced by the following: Documentation review revealed an annual elevator inspection was not conducted in 2024. The most recent annual elevator inspection certificate was found posted in the elevator and was dated 06/20/2019. It was a temporary certificate of occupancy/compliance and stated, "the following conditions must be met no later than 09/24/2019 or the owner will be subject to fine or order to vacate as stated in the attached inspection report, all violations should be corrected." The inspection report that indicated the violations and or the remedy of the violations could not be provided. In an interview at the time, the US FOIA (b)(6) [redacted] confirmed that inspections were not conducted in 2024. He stated that the elevator inspections for 2023 were conducted and that they would contact their elevator company for a copy of the certificates. No Further documentation regarding the elevators was provided. The facility's Administrator was notified of the	K 531	K531 Elevators. I. Immediate: The facility has contacted the elevator service company to complete the required annual elevator inspection and testing. The service company was contacted to provide the updated inspection and testing records that were missing. The elevator was inspected on 2/11/25 by the state NJ division of elevators, results several items needs addressing, facility has decided on going forward with replacing elevator. Please see work permit issued by DCA II. Others The facility has only one elevator and therefore no other areas were affected. III. Systemic changes. The facility has reviewed the service contract agreement for the elevator and included the annual inspection and testing as is required. A log of all service shall be maintained by the facility engineer specific to the elevator and be readily available for review. The reports of monthly service shall be presented to administration to show completion or required repairs for scheduling. V. The maintenance department was in-service by Administrator/designee IV. QAPI The Director of Maintenance will review the Records & Logs book for any cases of non-compliance. The Director of Maintenance submits the audit tool with all	

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 _____	**01/07/2025**

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
K 531	Continued From page 24 deficient practice at the Life Safety Code exit conference on 01/03/2025 at 12:30 PM. N.J.A.C 8:39-31.2(e) ASME A 17.1, A 17.3	K 531	cases of non-compliance to QAPI committee for review for 6 months. If there are no deficiencies found QAPI can recommend a reduced report to the semiannual then annually. V. plan if warranted. ; Director Maintenance/Designee Completion date: 2/26/25	
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	K 741		2/20/25

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 _____	01/07/2025

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
K 741	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/30/2024 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that metal containers with self-closing cover devices were readily available to all areas where smoking is permitted in accordance with NFPA 101:2012 Edition, Section 19.7.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:14 PM revealed a metal container with a self-closing cover device into which ashtrays can be emptied was not provided or readily available to the smoking area. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 01/03/2025 at 12:30 PM. N.J.A.C 8:39-31.2(e)	K 741	K741 Smoking 1 The facility has provided a metal waste container with self-closing lid in the smoking area The Facility respectfully states that all residents were potentially affected however, no residents were involved in this deficiency. 2. The facility reviewed all other spaces and determined them to be in compliance Systemic: The facility has reviewed the smoking area policy and no changes were required. Staff responsible for use and cleaning of the smoking area have been in-serviced by the maintenance director/designee on the policy and the use of cans. 3. The director of environmental services shall conduct daily audits to ensure the smoking area is in compliance. QAPI The Director of environment will review the smoking area for any cases of non-compliance. The Director of environment submits the audit tool with all cases of non-compliance to QAPI committee for review and adjustments as may be required for 6 months. If there are no deficiencies found QAPI can recommend a reduced report to the semiannual then annually. Director of Environmental Services/Designee Date	

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 _____	**01/07/2025**

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
K 741	Continued From page 26	K 741	02/20/25	
K 917 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/30/2024 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that electrical receptacles or cover plates supplied from the life safety and critical branched were provided with a distinctive color or marking in accordance with NFPA 99 sections 6.4.2.2.6, 6.5.2.2.4.2 and 6.6.2.2.3.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 12/30/2024 at 12:30 revealed all the electrical outlets in the corridor and nurse's station were white in color. In an interview at the time, the surveyor asked the US FOIA (b)(6) [redacted] if any of the electrical receptacle in the corridor were supplied from the generator in cases of emergency. The US FOIA (b)(6) [redacted] stated that the receptacle outside of the maintenance office and a receptacle at the nurse's station were connected to the generator. Upon further review, the US FOIA (b)(6) [redacted] confirmed that there were no distinctive color or markings on any	K 917	K 917 Electrical systems I. Immediate The Director of Maintenance purchased and installed red outlet covers and replaced the existing white covers on all the emergency power outlets including the outlet at 2nd floor nurse station and outside the maintenance office. II. Others The Facility respectfully states that all residents were potentially affected; however, no residents were directly involved in this deficiency. The facility reviewed all other spaces and determined them to be complying. III. Systemic Changes. The facility reviewed the emergency power policy and found it to be compliant. The facility reviewed the construction and renovation policy and determined there was a need to instruct outside workers on the importance of having the emergency power receptacles properly identified when replacing or working on the system. The administrator inserviced the maintenance director on the renovation	2/20/25

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 _____	**01/07/2025**

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
K 917	Continued From page 27 of the outlets supplied by the generator on the second floor. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 01/03/2025 at 12:30 PM. N.J.A.C 8:39-31.2(e) NFPA 99	K 917	policy to ensure that when outside workers are in the building they are aware of our protocols. The facility shall conduct monthly audits of the EES distribution to ensure all item connected are properly identified. IV. QAPI The Director of Maintenance will review the Records & Logs book for any cases of non-compliance. The Director of Maintenance submits the audit tool with all cases of non-compliance to QAPI committee for review and adjustments as may be required for 6 months. If there are no deficiencies found QAPI can recommend a reduced report to the semiannual then annually. V. Director Maintenance/Designee VI. 02/20/25	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete	K 918		2/20/25

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 _____	**01/07/2025**

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
K 918	Continued From page 28 simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 01/03/2025 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that maintenance and testing of generators in accordance with NFPA 99 Sections 6.4.4, 6.5.4, 6.6.4, NFPA 110, NFPA 111 and NFPA 70. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 09:59 AM revealed the generator contained a lead-acid battery. In an interview at the time the surveyor asked for monthly testing and recording of electrolyte specific gravity for the lead-acid batteries. The US FOIA (b)(6) confirmed that the battery was not a sealed lead-acid battery and stated that they would need to check the inspection logs to see if monthly	K 918	K 918 Electrical Systems EES I. Immediate: 1. The director of maintenance purchased a specific gravity tester for lead acid batteries. 2. The emergency generator log was updated to include a log point for the battery monitoring. All residents have the potential to be affected, however no residents were affected by the deficient practice. The facility has only one generator for supply of EES power and therefore no other areas were affected. Systemic changes: 1. The weekly maintenance log for the EES generator has been updated to include the specific gravity testing of all batteries required by the generator.	

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 _____	**01/07/2025**

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
K 918	Continued From page 29 testing was conducted. A documentation review at 10:13 AM revealed the US FOIA (b)(6) could not find record of the monthly testing and recording of electrolyte specific gravity and confirmed that it was not conducted. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 01/03/25 at 12:30 PM. N.J.A.C 8:39-31.2(e) NFPA 70, 99, 110, 111	K 918	QAPI The Director of Maintenance will review the Records & Logs book for any cases of non-compliance. The Director of Maintenance submits the audit tool with all cases of non-compliance to QAPI committee for review and adjustments as may be required for 6 months. If there are no deficiencies found QAPI can recommend a reduced report to the semiannual then annually. Completion Director of Maintenance/designee 2/20/25	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315437 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/4/2025 Y3

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0225	02/20/2025	LSC K0281	02/20/2025	LSC K0293	02/20/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0342	02/20/2025	LSC K0355	02/20/2025	LSC K0363	02/20/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0531	02/26/2025	LSC K0741	02/20/2025	LSC K0917	02/20/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	02/20/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
1/7/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315437 Y1	A. Building B. Wing Y2	3/4/2025 Y3

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 E0037 Reg. # 483.73(d)(1) LSC	Correction Completed 03/03/2025	ID Prefix E0041 Reg. # 483.73(e) LSC	Correction Completed 02/20/2025	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	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 1/7/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			