STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315274	A. BUILDING **01** B. WING _____	**10/19/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT LAURELTON, LLC	**475 JACK MARTIN BLVD** **BRICK, NJ 08724**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/18/2021 and Complete Care at Laurelton was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Complete Care at Laurelton is a single story, Type V Protected building that was built in January 1, 1988. The facility is divided into 6 smoke zones.	K 000		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 521		12/3/21

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

Electronically Signed | 11/06/2021

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	315274	A. BUILDING **01** B. WING _____	**10/19/2021**

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K 521	Continued From page 1 Based on observations and interview conducted on 10/18/2021, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 6 of 9 resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: During a tour of the building starting at 8:36 AM, in the presence of the facility's Administrator and Maintenance Director (MD), an inspection inside of nine (9) resident bathrooms was performed. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 6 of 9 resident bathrooms in the following locations: 1. At 8:41 AM, in Resident Room #114's bathroom, the surveyor observed an approximately 4" x 4" ventilation grill. When tested by placing a single ply of tissue across the grill, the tissue did not hold in place. The exhaust system did not function properly. 2. At 9:21 AM, in Resident Room #135's bathroom, the exhaust system did not function properly when tested. At this time, the MD confirmed that the bathroom exhaust system did not function properly. 3. At 9:54 AM, in Resident Room [redacted] bathroom, the exhaust system did not function properly when tested. 4. At 9:58 AM, in Resident Room [redacted]	K 521	K521- SS-E HVAC CFR(s): NFPA 101 CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " The 6 broken vents were identified to have been running off 2 different fan motors. These 2 fan motors were burnt out. They were taken out and replaced. " No residents were affected by the deficient practice. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE " All residents have the potential to be affected by the issues cited in the statement of deficiencies MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: " All fans have been labeled and a guide has been created to show the corresponding zones for which rooms each fan controls for ventilation. " New fan motors were installed on 10/27. Rooms were checked to ensure proper ventilation and no issues were identified. " Maintenance personnel were in-serviced on the facility□s police on	

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	315274	A. BUILDING **01** B. WING _____	**10/19/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT LAURELTON, LLC	**475 JACK MARTIN BLVD** **BRICK, NJ 08724**

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K 521	Continued From page 2 bathroom, the exhaust system did not function properly when tested. 5. At 10:03 AM, in Resident Room [redacted] bathroom, the exhaust did not function properly when tested. 6. At 10:45 AM, in Resident Room [redacted] bathroom, the exhaust did not function properly when tested. All the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. The Administrator was notified of these findings at the Life Safety Code exit conference at 1:30 PM on 10/18/2021. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521	Preventative Maintenance of Vents. MONITORING OF CORRECTIVE ACTIONS: " Weekly audits will be done by the Maintenance director/designee of all zones will be done for 3 months for the first 3 months and then monthly thereafter. Any issues found during the audit will be immediately addressed rectified. " Audit Findings will be reported to the Administrator as needed and on a monthly basis and reported in the QAPI Meeting on a Quarterly Basis. The QAPI Committee will determine the need for further audits and or action plans on a quarterly basis.	

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
315274 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	1/6/2022 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT LAURELTON, LLC	475 JACK MARTIN BLVD BRICK, NJ 08724

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 Reg. # NFPA 101 LSC K0521	Correction Completed 12/03/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
10/19/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO