STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Brook Rehabilitation and Healthcare Center	3718 Church Road Mount Laurel, NJ 08054

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Complaint #: 2614619 Based on interviews, record review and review of pertinent facility documents 09/18/2025 and 09/23/2025, it was determined that the facility failed to ensure a resident was protected from verbal and physical abuse on 12/18/24 when a house keeping staff was observed yelling and kicking a resident (Resident #4). The facility also failed to follow its policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program Resident. This deficient practice was identified for 1 of 9 residents and was evidenced as follows:According to the admission Record (AR), Resident #4 was admitted to the facility with diagnoses that include but not limited to: Unspecified Dementia (loss of cognitive function, thinking), Depression (feeling of severe despondency and dejection), and History of Falling. According to the Resident #4's Minimum Data Set (MDS), an assessment tool that provides a comprehensive assessment of a resident's functional capabilities, dated 07/04/2025, under Section C-Cognitive Patterns showed that the Resident had a Brief Interview for Mental Status (BIMS) Score of 7 out of 15 indicating Resident's cognition was severely impaired and totally dependent on staff for activities of daily living. A review of the residents Progress Notes (PNs) dated 12/18/2025 revealed: 'I spoke with [resident's name] and asked the resident if I could look at their skin and the resident agreed stating Sure. I assisted the resident to their bathroom and inspected their skin. The resident skin was clean, dry and intact except for the existing self-inflicted discoloration to right eye. The resident was cooperative and pleasant during and after. No s/s (sign and symptom) of anguish observed. The resident denied having pain when asked. A review of the facility submitted document to the New Jersey Department of Health (NJDOH), a facility reportable event (FRE), with attached facility's Summary and Conclusion, dated: December 18, 2024, Event: Allegation of Abuse. Under Narrative: It was witnessed by an employee of the activity department that a housekeeping aid was kicking [resident's name] in the side to get them to get up and go back to their room. Under Facility Investigation and Conclusion, With the allegation brought to our attention, staff witness statements/interview, and [housekeeping aid's name] phone interview the facility is not able to corroborate the allegation of abuse due to [housekeeping aid name] denying any interaction with the resident, the resident not having any recall of the event, no additional witnesses to the event and absence of resident injury as a result of the witnessed allegation. It was however concluded based on facility investigation, that the facility is not comfortable with [housekeeping aid name] guarded interaction and failure to engage in the facility investigation. As a result, the facility is not comfortable with furthering the employment relationship with [housekeeping aid name] and have ended his employment relationship with [facility's name] effective 12/30/2024. On 09/18/2025 at 12:02 P.M., the surveyor interviewed the Activity staff who stated on 12/18/2024, she observed Resident #4 laying on the floor by their doorway. She stated the housekeeping staff was on the unit at the time and she observed him yelling and telling the resident to get back in their room and kicking Resident #4. When asked by the surveyor which part of the resident's body did (continued on next page)

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.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the housekeeping staff kicked, she said, I don't recall specifically where, but I remembered that he was kicking the resident and yelling. I told him he cannot do that, I told him We are not allowed to yell or kick the residents. I told the housekeeping staff to stop, and he did. I immediately informed my supervisor and the Administrator. She further stated, the housekeeping staff was not seen in the building after the incident occurred that day. On 09/18/2025 at 12:24 P.M., during and interview with the Licensed Nursing Home Administrator (LNHA) in the presence of the Acting Director of Nursing (ADON), the LNHA said the activity aid observed the housekeeping staff kicking and using his foot to slide Resident #4 into their room as the resident was sitting in the hallway. The LNHA stated the activity aid immediately stopped the housekeeping staff and reported the incident to her supervisor and they informed me of the incident. She said, the housekeeping staff had left for the day, he was immediately notified via a phone call about the abuse allegation. The LNHA further stated, yes it was substantiated that abuse occurred after our investigation. When asked if the facility's policy was followed, the LHNA said; no, the housekeeping staff did not follow the facility's policy on abuse. The expectation is for all staff to follow the facility's Abuse Policy. On 09/18/2025 at 1:00 P.M., the surveyor attempted to interview Resident #4 but was unable to conduct an in-person interview due to the resident's severe cognitive impairment. A review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, with Revision date of April 2021, under Policy Statement reveals: Resident have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Under Policy Interpretation and Implementation reveals: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including but not necessarily limited to: a. facility staff; . NJAC 8:39-4.1 a(5)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews, medical record reviews, and review of other pertinent facility documents, it was determined that the facility failed to conduct a thorough investigation for an allegation of verbal abuse. This deficient practice was identified for 1 of 9 residents reviewed for abuse (Resident #2), and was evidenced by the following:A review of the Facility Reportable Event (FRE) submitted to the New Jersey Department of Health (NJDOH) dated 8/01/24, included an allegation of rough handling of Resident #2.According to the admission Record (AR) face sheet, Resident #2 was admitted to the facility with diagnoses which included but were not limited to; unspecified sequelae of cerebral infarction (long-term, residual problems after a past stroke), acute embolism and thrombosis (occurs when a clot (or other foreign material) breaks free and travels through the bloodstream, blocking a vessel elsewhere), gangrene (the death of body tissue that occurs when blood supply is interrupted) and chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing).A review of the Minimum Data Set (MDS), an assessment tool dated 7/21/24, Resident #2 had a Brief Interview of Mental Status (BIMS) score of 10/15, which indicated Resident #2's cognition was moderately impaired.A review of the Progress Notes (PNs) written by the Director of Social Worker, revealed that a care conference via telephone was set up for 8/02/24 with Resident #2's Representative (RR). A second PNs written by the Director of Nursing (DON #1), revealed that a care conference was conducted on 8/02/24, related to concerns the RR had regarding Resident #2's care.A review of the FRE packet that the facility provided to the surveyor included a piece of paper, signed by the Unit Manager of Resident #2's unit regarding the incident on 7/31/24. It indicated that a care conference had occurred on 8/02/24. This paper did not include a date that it had been created, and it also was not included in the original FRE paperwork submitted to the NJDOH.A review of the grievances for Resident #2 revealed that a grievance had been filed 8/02/24, and under the grievance details, it indicated, during care conference [RR] expressed concerns of nursing care and how staff was rude during room transfer.On 9/18/25 at 10:57 A.M., the surveyor reviewed with DON #2 and the Licensed Nursing Home Administrator (LNHA) that the FRE indicated that the RR notified the facility of alleged verbal abuse on 8/02/25, and informed them that no evidence was provided that the allegation was investigated.On 9/18/25 at 12:22 P.M., the surveyor conducted an interview with DON #2 and the LNHA together. The surveyor requested DON #2 to define abuse, and she stated that abuse could by physical, mental, or anything related to misappropriation.On 9/23/25 at 10:36 A.M., the surveyor conducted a telephone interview DON #1, the previous DON. When asked if he recollected the FRE and Resident #2, he stated that he did but was unable to recall the exact time frame. DON #1 further stated that standard procedure for the facility was to file a report to the NJDOH and then to conduct a facility investigation that would either substantiate or unsubstantiate an allegation that was brought forward.On 9/23/25 at 11:57 A.M., the surveyor interviewed DON #2 and the LNHA together. DON #2 was questioned regarding the grievance from 8/02/24, that stated that the Certified Nursing Assistant (CNA) was rude to Resident #2. DON #2 stated that any time a resident reported that they were uncomfortable regarding a verbal communication, we (the facility) would investigate that. At that time, the surveyor requested an investigation regarding the grievance from 8/02/24. The facility stated they did not have an investigation for this grievance.When DON #2, was questioned why an investigation was not done regarding the CNA's alleged rudeness by RR, she stated she could not attest to that as both she and the LNHA were not working at the facility at the time.A review of the facility's policy titled Grievance and Complaint Procedure dated January 2022, included the following information under Policy Interpretation and Implementation:6. Upon receipt of a grievance or complaint, the facility administrator or designee will review (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and investigate the allegation and compile documentation of such findings within a reasonable timeframe of receiving the grievance/complaint.7.The administrator or designee will coordinate actions with the appropriate agencies, depending on the nature of the grievance. All alleged cases of resident abuse, neglect, and financial exploitation will be reported and investigated in accordance with facility policy and state law.A review of the facility's policy titled Accidents and Incidents-Investigating and Reporting last revised January 2017, included the following information under Policy Interpretation and Implementation:1. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident.2. The following data, as applicable, shall be included on the form:a. The date and time the accident or incident took place;b. The nature of the injury/illness (e.g./ bruise, fall, nausea, etc.);c. The circumstances surrounding the accident or incident;d. Where the accident or incident took place;e. The name(s) of witnesses and their accounts of the accident or incident.NJAC 8:39-4.1(a)5