STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315008	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Manor Healthcare and Rehabilitation Center	18 W Laurel Road Stratford, NJ 08084

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess the risk of entrapment, try alternatives, and/or obtain informed consent before initiating side rails for seven (Residents (R)1, R11, R83, and R87) of seven residents reviewed for side rails. These failures could result in serious injury or death to residents. Findings include: Review of the facility policy titled Side Rail, dated 12/24, provided by the facility revealed It is the policy of this facility to provide residents with side rails as an enabler for bed mobility. Procedure: 1. Upon admission, the nurse will assess the need for side rails using the Side Rail Assessment form in [Electronic Medical Record software]. 2. Side rails will be monitored and re-evaluated on a quarterly basis (based on MDS [Minimum Data Set] schedule) or as warranted by the resident's condition. 3. Residents may request the use of side rails for their own personal reasons. It is the resident's right that this decision must be honored. 4. If resident's family requests side rail use, the nurse will assess the resident and the request, discuss risks involved with its use with the resident and family and describe alternative individualized care practices (i.e. a lower bed) that may be safer and appropriate for the resident. 1. Review of R11's admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including muscle weakness and abnormalities of gait and mobility. Review of R11's significant change Minimum Data Set (MDS) assessment under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 08/07/25, revealed she scored five out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Review of R11's Care Plan, located under the Care Plan tab of the EMR dated 10/25/23, revealed The resident used side rails as an enabler. Interventions in place were to use side rails for turning and repositioning. Further review no updates to care plan since 10/25/23.Review of R11's Physician Orders, located under the Orders tab in the EMR, dated 07/11/23, revealed .bilateral quarter side rails used as an enabler. Review of R11's Resident Evaluation/Bedrail Assist Device, located under the Observations tab in the EMR and dated 01/17/25, 04/23/25 and 07/22/25, revealed no evidence of alternates explored, or risk versus benefits. During an interview on 08/27/25 at 2:15 PM Registered Nurse/Unit Manager (RN/UM) 1 stated residents were assessed for side rails on admission, and they were asked if they wanted side rails. She said she thought that risks and benefits were discussed but she was unsure where these signed consents were located or if they explored alternates prior to use. During an interview on 08/27/25 at 2:27 PM Licensed Practical Nurse/Unit Manager (LPN/UM)1 said staff were not exploring alternatives prior to using bedrails for residents. She also stated they do not discuss risk versus benefits with residents, but they did inform them bedrails were considered a restraint and ask them if they wanted them or not. During an interview on 08/28/25 at 8:57 AM the Director of Nursing (DON) said staff would ask for verbal consent for side rail use upon admission but it was not documented. She said the nurse would discuss risk versus benefits, but it was not documented. She said staff asked residents if they wanted side rails and they would be provided at that time. She was unaware of alternates were explored prior to use. 2. Observations on 08/25/25 at (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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2:00 PM, 08/27/25 at 10:00 AM, and 08/28/25 at 1:30 PM revealed R6 laying on his bed with both half siderails in the raised position. Review of R6's Electronic Medical Record (EMR) under the Clinical Census tab revealed he had been admitted on [DATE] at 9:15 PM. Review of R6's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/03/25 under the MDS tab revealed his Brief Interview for Mental Status (BIMS) score was 0 out of 15. This indicated he had severe cognitive impairment. Review of R6's Admission/readmission Evaluation found under the Assessment tab completed on 06/03/25 revealed the side rail assessment section. This assessment revealed he had an alteration in safety awareness due to his cognitive decline, he had a history of falls, he had poor bed mobility or had difficulty moving to a sitting position on the side of the bed, had difficulty with balance or poor trunk control, was on medications that required increased safety precautions, was currently using the side rail for positioning or support, and he expressed his desire for the siderails. The interventions checked included: lower the bed to the floor, provide restorative care to enhance abilities to stand, transfer, and walk safely, provide frequent staff monitoring at night, periodic assisted toileting for resident at night, and visual and verbal reminders to use the call bell. Recommendations included the use of bilateral half side rails. 3. Observations on 08/25/25 at 1:45 PM revealed R87 was laying in her bed with her bilateral half siderails in the raised position. Review of R87's (EMR) under the Clinical Census tab revealed she had been admitted on [DATE]. Review of R87's admission MDS with an ARD of 08/14/25 under the MDS tab revealed her BIMS score was 0 out of 15. This indicated she had severe cognitive impairment. Review of R87's Admission/readmission Evaluation found under the Assessment tab completed on 08/08/25 revealed the side rail assessment section. This assessment revealed she had an alteration in safety awareness due to her cognitive decline, she had a history of falls, she had poor bed mobility or had difficulty moving to a sitting position on the side of the bed, had difficulty with balance or poor trunk control, was on medications that required increased safety precautions, and was currently using the side rail for positioning or support. The interventions checked included: provide restorative care to enhance abilities to stand, transfer, and walk safely, provide frequent staff monitoring at night, periodic assisted toileting for resident at night, and visual and verbal reminders to use the call bell. Recommendations included the use of bilateral half side rails. Interview on 08/27/25 at 10:48 AM with RN-UM1 said the DON does the review of the care plan. She said all the beds had side rails attached to them. She said if the resident did not need the side rails they were just left down. She agreed most of the residents had side rails on their beds, including R6 and R87. 4. Review of R1's quarterly MDS with an ARD date of 08/01/25, located in the MDS tab of the EMR, revealed an admission date of 01/23/23, a BIMS score of 11 out of 15, indicating R1's cognition was moderately impaired, and had a diagnosis of seizure, gastrostomy status, and acute respiratory failure with hypoxia. Review of R1's Orders, located in the EMR under the Order tab revealed no order for side rails. Review of R1's Care Plan, dated 07/09/24, located in the EMR under the Care Plan tab revealed R1 use side rails as an enabler. Interventions included Discuss and record, with the resident/family the risk and benefits of side rails, Ensure valid consent on Chart prior to initiating siderails, and Evaluate the resident use of siderails and continuing risk/benefits and the need for ongoing use upon admission, significant changes, annually and quarterly. Review of R1's admission evaluation, dated 01/23/23, located in the EMR under the Assessment tab revealed no side rail assessment or consent for side rails. Review of R1's siderail assessment, dated 05/08/25, located in the EMR under the Assessment tab revealed R1's was a high risk for fall but the assessment did not include the risk of entrapment or if informed consent was obtained. The assessment was completed by Corporate Registered Nurse (CRN). During an interview on 08/27/25 at 9:19 AM, LPN2 was asked why R1 had side rails on his bed. LPN2 stated, I can't answer that question. During an interview on 08/27/25 at 10:47 AM, the DON was asked why R1 had side rails on his bed. DON stated they were used as enablers and R1 could use them. DON stated side rail assessments were completed quarterly. DON was asked where the informed consent would be documented. DON stated there are no written consents, only verbal, which was obtained during (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admission. DON stated she was working on a written informed consent form. During an interview on 08/27/25 at 12:36 PM, Certified Nurse Aide-Agency (CNA - A)5 was asked if she was R1's nurse aide and CNA-A5 stated, Yes. CNA-A5 was asked why R1 had side rails on his bed. CNA-A5 stated she was agency, and she didn't know why, and she didn't know what the facility policy was concerning side rails. CNA-A5 went on to say she was the wrong person to ask about it. During a follow up interview on 08/28/25 at 10:00 AM, the DON was asked about R1's side rail assessment not addressing the risk of entrapment and risk verses benefits as R1 had a seizure diagnosis and cognition impairment. DON stated again that only verbal consent was obtained. DON asked why the entrapment or risk verse benefits were not in the assessments at admission or the 05/08/25 assessment. DON acknowledged the risk of entrapment and risk verses benefits were not documented. DON confirmed the facility's side rail policy didn't include risk of entrapment, risk verses benefits and informed consent. On 08/28/25 at 11:14 AM, R1 was awake in bed with his gastrostomy feeding in progress while watching television and side rails in the up position. R1 was asked if he could use his side rails to move himself in bed. R1 stated, Not too good. During an interview on 08/28/25 at 4:33 PM, CRN was asked if she completed R1's 05/08/25 side rail assessment. CRN stated, Yes. CRN was asked about the assessment not addressing the risk of entrapment in the document and if she was aware of the requirement. CRN confirmed the risk of entrapment was not in the assessment and was not aware of the requirement. CRN stated a section could be added. NJAC 8:39-27.1(a)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure that an accurate Preadmission Screening and Resident Review (PASARR) Level I assessment was completed after admission for one resident (Resident (R) 110 out of 24 sampled residents.Findings include:Review of R110's "admission Record," located in the "Profile" tab of the EMR, revealed R8 admitted to the facility on [DATE] with diagnoses including bipolar disorder, and anxiety disorder. Review of R110's NJ [New Jersey] Department of Human Services Pre-admission Screening and Resident Review (PASRR) Level I screen, dated 08/21/25 and located in the resident's EMR under the Miscellaneous tab, revealed no indication of mental illness identified. During an interview on 08/27/25 at 2:40 PM the Social Services Director (SSD) said she was not aware that R10 PASARR level I was not completed correctly. She stated that staff are usually looking for diagnosis like bipolar and schizophrenia but agreed that any mental illness diagnosis should be listed on the level I. During an interview on 08/28/25 at 8:57 AM the Director of nursing stated she expected staff to complete all assessments accurately and correctly. NJAC 8:39-5.1(a)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to ensure five of five newly admitted residents (Residents (R)6, R57, R87, R105, and R108) had documentation the Baseline Care Plan had been reviewed with the resident and/or representative within 48 hours, and a copy of the Care Plan had been offered. Findings Include: Review of the facility's policy titled, Care Plans - Comprehensive revised June 2025 indicated: The resident's baseline care plan is developed within 24-48 hours through the admission assessment. There was no procedure of the resident and/or their representative involvement with the baseline care plan. 1. Review of R6's Electronic Medical Record (EMR) under the Clinical Census tab revealed he had been admitted on [DATE]. Review of R6's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/03/25 under the MDS tab revealed his Brief Interview for Mental Status (BIMS) score was 0 out of 15 which indicated he had severe cognitive impairment. Review of R6's Admission/readmission Evaluation found under the Assessment tab revealed his Base Line Care Plan was completed on 06/04/25. There was no documentation the Care Plan had been reviewed with his representative. Review of R6's Social Services Admission/readmission Evaluation found under the Assessments tab completed on 06/06/25 revealed his representative did not participate in the assessment. Telephone interview on 08/28/25 at 1:40 PM with Family Member (FM)1 revealed she did not remember when the care plan had been reviewed. She was not offered a copy of the care plan. 2. Review of R87's EMR under the Clinical Census tab revealed she had been admitted on [DATE]. Review of R87's admission MDS with an ARD of 08/14/25 under the MDS tab revealed her BIMS score was 0 out of 15. This indicated she had severe cognitive impairment. Review of R87's Admission/readmission Evaluation found under the Assessment tab revealed her Base Line Care Plan was completed on 08/11/25. There was no documentation the Care Plan had been reviewed with his representative. 3. Review of R105's EMR under the Clinical Census tab revealed she had been admitted on [DATE]. Review of R105's EMR Social Service Admission/readmission Evaluation under the Assessments tab was completed on 08/20/25 the evaluation indicate a BIMS was completed, and her score was five out of 15 which indicated severe cognitive impairment. Review of R105's Admission/readmission Evaluation found under the Assessment tab revealed her Base Line Care Plan was completed on 06/04/25. There was no documentation the baseline Care Plan had been reviewed with her representative. Interview on 08/27/25 at 4:50 PM with the Director of Nursing (DON) revealed when a resident was admitted the admission assessment was completed by the nurse, an initial care plan was generated. She stated there was no documentation the resident and/or representative reviewed the initial care plan and was offered a copy within 48 hours of admission. 4. Review of R57's admission Record, located in the Profile tab of the EMR revealed admission to the facility on [DATE] with diagnoses of type 2 diabetes mellitus, chronic kidney disease, hypertension and diverticulosis. Review of R57's admission MDS under the MDS tab of the EMR, with an ARD of 08/06/25 revealed the BIMS, revealed a score of 11 out of 15, which indicated moderately impaired cognition. This MDS assessment further indicated R57 required substantial/maximal assistance with toileting hygiene, bathing, and lower body dressing. Review of the EMR revealed no documentation in the medical record that the baseline care plan, developed upon admission, had been provided or reviewed with R57. Interview with R57 during initial rounds on 08/25/25 at 1:35PM, R57 stated she had not attended a care planning meeting or discussed her care with staff. 5. Review of R108's admission Record, located in the Profile tab of the EMR revealed admission to the facility on [DATE] with diagnoses of type 2diabetes mellitus, hypertension, bacteremia, and cellulitis of left lower limb. Review of R108's admission MDS under the MDS tab of the EMR, with an ARD of 08/06/25 revealed the BIMS, revealed a score of 15 out of 15, indicating intact cognition. Further review of the same MDS assessment revealed R108 required (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	substantial/maximal assistance with toileting hygiene, bathing, lower body dressing and was dependent on staff for putting on/taking off his footwear. Review of the Electronic Medical Record (EMR) revealed no documentation in the medical record that the initial baseline care plan, developed upon admission, had been provided or reviewed with R108. Interview with R108 on 08/28/25 at 4:10PM revealed that he had not attended a Care Plan meeting or discussed his care with staff. NJAC 8:39-11.1NJAC 8:39-11.2

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to follow physician orders to hold medication when blood pressure was outside of the parameters for two of two residents (Residents (R)1 and R8) reviewed for medications and ensure the appropriate use of a wander guard device for one of two residents (R11) reviewed for wandering. These failures had the potential to cause residents' conditions to exacerbate and affect quality of care.Findings include: Review of the facility's policy titled Medication Administration, reviewed 06/25It is the policy and procedure of the facility to provide the nursing staff with anunderstanding of proper medication administration. 1. Hold parameters: Check blood pressure and/or pulse rate immediately prior to pouring. Review of the facility policy titled, Wander Guard, revised 11/2021 revealed, it is the policy and procedure of this facility to provide a safe environment for its residents should a resident be identified as a wanderer. A wander guard will be applied for a resident with wandering potential upon admission or as needed based on assessment. 1. Review of R1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 08/01/25, located in the MDS tab of the electronic medication record (EMR), revealed an admission date of 01/23/23, a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating R1's cognition was moderately impaired, and had a diagnosis of orthostatic hypotension, gastrostomy status, and acute respiratory failure with hypoxia. Review of R1's Orders, dated 07/19/24, located in the EMR under the Order tab revealed Midodrine HCl Oral Tablet 5 MG [milligram] (Midodrine HCl), Give 1 tablet via PEG [percutaneous endoscopic gastrostomy]-Tube three times a day for hypotension monitor b/p [blood pressure] weekly. hold for SBP [systolic blood pressure] greater than 120. Review of R1's Care Plan, located in the EMR under the Care Plan tab revealed no care plan for hypotension or treatment. Review of Medical Clinician Progress Note, dated 04/06/25, located in the EMR under the Progress Note tab revealed Pt [patient] seen and examined lying in bed this AM sleeping, opens eyes to voice and is pleasant and cooperative. He reports feeling dizzy, BP reviewed and stable. He has a standing order of midodrine. Review of R1's August 2025 Medication Administration Record (MAR) located in the EMR under the Order tab revealed Midodrine was administered when R1's SBP was greater than 120. This included:On 08/02/25 at 9:00 AM, blood pressure measured 122/78On 08/13/25 at 1:00 PM, blood pressure measured 139/69On 08/15/25 at 9:00 AM, blood pressure measured 134/78On 08/15/25 at 1:00 PM, blood pressure measured 134/78 Review of R1's July 2025 MAR located in the EMR under the Order revealed Midodrine was administered when R1's SBP was greater than 120. This included:On 07/03/25 at 1:00 PM, blood pressure measured 124/82On 07/04/25 at 5:00 PM, blood pressure measured 128/79 Review of R1's June 2025 MAR located in the EMR under the Order revealed Midodrine was administered when R1's SBP was greater than 120. This included:On 06/02/25 at 9:00 AM, blood pressure measured 134/79On 06/02/25 at 1:00 PM, blood pressure measured 130/76On 06/11/25 at 1:00 PM, blood pressure measured 122/74On 06/16/25 at 1:00 PM, blood pressure measured 124/76 Review of R1's Pharmacist Recommendations, dated 01/11/25, 02/06/25, 03/11/25, 04/05/25, 05/06/25, 06/05/25, 07/14/25, and 08/07/25, provided by the facility, revealed Medication error(s) noted. Midodrine is not always held as required by the physician's hold order. Please review and follow the physician's order. During an interview on 08/27/25 at 12:28 PM, the Director of Nursing (DON) was asked about R1's physician order for Midodrine and if she was aware R1's Midodrine wasn't always held when his SBP was greater than 120 per the July 2025 and August 2025 MAR. DON stated she was aware. DON went on to say, it's been an ongoing education with staff. DON stated staff have been counseled, reprimanded and more education has been provided to staff about the importance of following the physician's order to hold his medication when his blood pressure was outside of the parameters. DON stated the situation has improved and there has been no negative outcome for R1. During a telephone interview on 08/28/25 at 10:22 AM, the Consulting Pharmacist (C.Rx) was asked about R1's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Midodrine and should the nurses hold Midodrine if R1's SBP was greater than 120. The C.Rx stated, Yes. C.Rx was asked what could happen if the medication was not held when R1's SBP is greater than 120. C.Rx stated, there is no negative effects because his current blood pressure isn't too off. C.Rx went on to say, if it was, we might see headaches, hypertensive effects. C.Rx stated she has addressed the issue of not holding Midodrine in her monthly reviews. C.Rx stated the facility needs to educate their staff. 2. Review of R8's annual MDS with an ARD date of 07/30/25, located in the MDS tab of the EMR, revealed an admission date of 07/14/19, a BIMS score of 15 out of 15, indicating R8's cognition was intact, and had a diagnosis of hypertension, heart failure, and diabetes mellitus. Review of R8's Care Plan, dated 03/26/24, located in the EMR under the Care Plan tab revealed [R8] have [sic] HTN [hypertension]. Interventions included Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate (Tachycardia) and effectiveness and Obtain blood pressure readings as ordered. Take blood pressure readings under the same conditions each time. Review of R8's Orders, revised 05/14/25, located in the EMR under the Order tab revealed Hydralazine HCl Oral Tablet 25 MG (Hydralazine HCl), Give 1 tablet by mouth every 8 hours for HTN hold for sbp less than 120. Review of R8's August 2025 MAR, located in the EMR under the Order tab revealed Hydralazine was administered when R8's SBP was less than 120. This included:On 08/01/25 at 2:00 PM, blood pressure measured 108/55On 08/08/25 at 2:00 PM, blood pressure measured 115/66 Review of R8's July 2025 MAR, located in the EMR under the Order tab revealed Hydralazine was administered when R8's SBP was less than 120. This included: On 07/06/25 at 2:00 PM, blood pressure measured 104/42On 07/11/25 at 2:00 PM, blood pressure measured 116/51On 07/28/25 at 2:00 PM, blood pressure measured 116/73 Review of R8's June 2025 MAR, located in the EMR under the Order tab revealed Hydralazine was administered when R8's SBP was less than 120. This included:On 06/02/25 at 2:000, blood pressure measured 118/72On 06/21/25 at 2:00, blood pressure measured 110/50 Review of R8's Pharmacy Recommendations, dated 01/11/25, 06/05/25, 07/14/25, and 08/07/25, provided by the facility, revealed Medication error(s) noted. Hydralazine is not always held as required by the physician's hold order. Please review and follow the physician's order. During an interview on 08/27/25 at 12:28 PM, the DON was asked about R8's physician's order for hydralazine and if she was aware R8's hydralazine wasn't always help when her SBP was less than 120. DON stated she was aware. DON went on to say, it's been an ongoing education with staff and staff have been counseled, and more education has been provided to staff. DON stated the situation has improved and R8 has had no negative outcome because of her medication not held when her blood pressure was outside of parameters. On 08/27/25 at 4:08 PM, R8's was awake in bed, dressed and groomed. R8 was asked if she was aware of any time she was given her blood pressure medication when her blood pressure was too low. R8 stated she didn't think so. During a telephone interview on 08/28/25 at 10:30 AM, C.Rx was asked about R8's Hydralazine and should the nurses hold the medication if R8's SBP was less than 120. C.Rx stated, Yes. C.Rx was asked what could happen if Hydralazine was not held and R8's SBP was less than 120. CP.Rx stated there would be no negative effects with her because R8's blood pressure reading isn't too out of range. C.Rx went on to say, but if it was 90 it could cause hypotensive effects, but no negative effects so far. C.Rx stated staff need education and they have been doing better. 3. Review of R11's admission Record located in the Profile tab of the EMR revealed she was admitted to the facility on [DATE] with diagnoses including muscle weakness and abnormalities of gait and mobility. Review of R11's significant change MDS assessment under the MDS tab of the EMR, with an ARD of 08/07/25, revealed she scored five out of 15 on the BIMS, indicating severe cognitive impairment. Further review revealed no wandering behavior was exhibited. Review of R11's Care Plan, located under the Care Plan tab of the EMR dated 10/29/23, revealed The resident was care planned for risk for elopement and wears a wander guard. Interventions in place were to place wander guard on resident. Further review no updates to care plan since 10/29/23. Review of R11's Physician Orders, located under the Orders tab in the EMR dated 11/08/23 revealed wander guard for elopement prevention. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315008	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Manor Healthcare and Rehabilitation Center	18 W Laurel Road Stratford, NJ 08084

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R11's Elopement Risk Assessment located under the Observations tab in the EMR dated 01/17/25, 04/23/25 and 07/22/25 revealed R11 was not at risk for elopement.Review of R7's General Notes, located under the Notes tab of the EMR, dated 03/27/25 through 08/27/25, revealed no documentation of any wandering or exit seeking behaviors. During an interview on 08/27/25 at 2:01 PM Certified Nurse Aide (CNA)3 said R11 like to attend activities regularly and enjoy coloring. R11 can propel herself up and down the hallway but has never been exit seeking and is not a wanderer. She stated R11 knows where she is going and goes there. During an interview on 08/27/25 at 2:15 PM Registered Nurse/Unit Manager (RN/UM) said R11 really enjoyed attending activities and likes bingo. She was able to self-propel throughout the facility and was aware of where her room was and what floor her room was located on. She has never personally seen her exit seeking or making threats to leave. She also stated if a resident was assessed to not be an elopement risk they should not have a wander guard. During an interview on 08/28/25 at 8:57 AM the Director of Nursing (DON) stated if a resident was assessed not to be an elopement risk they should not have a wander guard. NJAC 8:39-27.1(a)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. A total of four errors occurred out of 25 opportunities for error for two of five residents (Resident (R) 82, and R 108) observed for medication administration. The facility's medication error rate was 16%. The findings include: Review of the Medication Administration Policy reviewed date 06/2025 revealed under Policy, It is the policy and procedure of the facility to provide the nursing staff with an understanding of proper medical administration .Under Medication Timing item 2. revealed Medication ordered with food may be administered with milk and graham crackers (or similar items). 3. Medication ordered with meals should be given with the meal (i.e. Metoprolol). 4. Medication ordered before a meal should be specific to manufacturer's recommendation and administered prior to the start of the meal.). 1.Review of R82's admission Record, located in the Profile tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease and hypertension. Review of R82's admission Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 08/01/25 revealed the Brief Interview for Mental Status (BIMS), revealed a score of 11 out of 15, which indicated moderately impaired cognition. Observation of Licensed Practical Nurse (LPN) 7 on 08/27/25 at 7:50 AM revealed LPN7 prepared R82's medication and placed one Amox-Clav 875-125 (Amoxicillin/Potassium Clavulanate) tablet, and Metoprolol Succinate ER 25mg 1/2 tablet in a small plastic medication cup. LPN7 then moved toward R82 and administered the medication. The medications were administered without the offer of food and before R82 had his breakfast meal. Review of the Physician's Orders in the EMR under the Orders tab revealed R82 was prescribed Amoxicillin/Potassium Clavulanate one tablet every twelve hours, to be given with food or meals for the treatment of Emphyema [sic]. Further review of the physician's orders revealed Metoprolol Succinate Extended Release (ER) was to be administered with meals for the treatment of hypertension. Interview with LPN 7 at the time of observation confirmed that she should have administered the medication with his breakfast meal. 2. Review of R108's admission Record, located in the Profile tab of the EMR revealed admission to the facility on [DATE] with diagnoses of type 2 diabetes mellitus. Review of R108's admission (MDS) under the MDS tab of the EMR, with an ARD of 08/06/25 revealed the BIMS, revealed a score of 15 out of 15, indicating intact cognition. Observation on 08/27/25 at 8:38 AM revealed LPN7 prepared R108's Metformin one 500miligram (mg) tablet and placed in a plastic medication cup. In addition, LPN7 prepared insulin from a vial of Insulin Lispro Injection Solution. LPN7 then drew eight units, the correct dosage of insulin and administered the insulin to R108 after he had consumed his breakfast meal. Interview with LPN7 at the time of observation confirmed that she should have administered the insulin prior to the resident eating his breakfast meal. Review of the Physician's Orders in the EMR under the Orders tab revealed R108 was prescribed Metformin one 500mg tablet twice a day, to be given with meals. Further review of the physician's orders revealed Insulin Lispro Injection Solution eight units were to be administered before meals for the treatment of Type 2 Diabetes Mellitus. Observation of the R108 at the time of observation revealed the resident had finished eating his breakfast in his room prior to the medication being administered, as evidence by an empty food tray. R108 confirmed he had eaten his breakfast and commented it was very good. Interview with Consulting Pharmacist (C. Rx) on 08/28/25 at 10:39 AM revealed administration of medications should be administered as ordered by the prescribing physician. The C. Rx further stated that the prescribing physician should be notified of medication discrepancies. Interview with the Director of Nursing (DON) on 08/28/25 at 10:00AM revealed that the facility expectation is that medications are to be administered as prescribed by the attending physician. NJAC 8:39-29.2(d)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure one of one Resident (R)105 with a tracheostomy, corrugated respiratory tubing which delivered humidified oxygen, and a moisture collection bag had been kept off of the floor. Having the tubing and collection bag on the floor put R105 at risk of infection.Findings include: Review of the facility's policy titled, Oxygen Tubing and Respiratory Products revised October 2024 indicated, All oxygen tubing would have been properly stored to prevent the transmission of infection. If the tubing falls on the floor, it shall immediately be discarded and replaced to prevent contamination. Review of R105's Electronic Medical Record (EMR) Census List under the tab Census revealed she had been admitted on [DATE]. Review of R105's EMR Medical Diagnosis under the tab Medical Diagnosis revealed she had been admitted with a fracture of the base of her skull, epidural hemorrhage, chronic obstructive pulmonary disease, and previous acute respiratory failure which resulted in a tracheostomy. Review of R105's EMR Social Service Admission/readmission Evaluation under the Assessments tab was completed on 08/20/25. A Brief Interview for Mental Status was completed, and her score was five out of 15 which indicated severe cognitive impairment. Review of R105's EMR Care Plan under the Care Plan tab revealed focus area of her tracheostomy related to ineffective airway clearance. Her goals included R105 will have no s/sx [signs and/or symptoms] of infection through the review date. Interventions included Perform tracheostomy care every shift and Give humidified oxygen as prescribed. Observations on 08/25/2025 at 11:01 AM, on 08/26/25 at 1:15 PM, and on 08/27/25 at 9:25 AM revealed R105's corrugated humidified oxygen tubing with a moisture collection bag between two pieces of the tubing was laying on the floor beside her bed. She was laying in her bed. Interview on 08/25/25 at 4:00 PM with the Director of Nursing (DON) revealed R105 has a tracheostomy and uses a humidified oxygen delivery system. She said the corrugated respiratory tubing is changed daily on the night shift. Interview on 08/27/25 at 9:35 AM with Licensed Practical Nurse (LPN)3 revealed she has had training on tracheostomy care previously by the DON. She had a refresher on the care this morning by Registered Nurse/Unit Manager (RN UM)1. Observation and interview on 08/27/25 at 4:45 PM with LPN3 revealed the tubing for R105 was on the floor with the moisture collection bag also on the floor. She agreed the tubing being on the floor was an opportunity for infection. She said that they had not found a way to keep the tubing off the floor as it frequently was found laying on the floor. Interview on 08/28/25 at 9:00 AM with the DON revealed she had not been aware R105's corrugated humidified oxygen delivery system was laying on the floor. She agreed there was a chance for transmission of an infectious process. She agreed a system to keep it off of the floor should have been investigated sooner. NJAC 8:39-19.4