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	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Bay Health & Rehabilitation Center	32 Laurel Avenue Keansburg, NJ 07734

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Complaint #: NJ187696Based on interviews, review of medical records, and other pertinent facility documentation on 6/30/2025, it was determined that the facility failed to implement care plan interventions for 3 of 3 residents who were identified as an elopement risk. This deficient practice was evidenced by the following:1.According to the admission Record (AR), Resident #1 was admitted to the facility with diagnoses which included but were not limited to: Unspecified Convulsions, Unspecified Cerebral Infarction (Stroke), and Hypertension.According to the Quarterly Minimum Data Set (MDS), an assessment tool dated 6/5/2025, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated the resident's cognition was severely impaired. The MDS also indicated that Resident #1 had an elopement alarm in place and was able to ambulate with set-up assistance. According to Resident #1's Care Plan (CP) with an initiated date of 10/14/2024, and a revision date of 11/04/2024. The CP revealed that the resident presented as a risk for elopement. Further review of Resident #1's CP revealed that the resident eloped from the building on 11/3/2024 and 6/23/2025. In addition, the CP revealed the following intervention: place on walker's club and provide pictures to the first floor, second floor, and reception area (date initiated 11/4/2024). 2. According to the AR, Resident #2 was admitted to the facility with diagnoses which included but were not limited to: Hypertension, Anxiety Disorder, and Depression.According to the Quarterly MDS, an assessment tool dated 5/17/2025, Resident #2 had a BIMS score of 8 out of 15, which indicated the resident's cognition was moderately impaired. The MDS also indicated that Resident #2 had an elopement alarm in place and was able to ambulate with supervision.According to Resident #2's CP with an initiated date of 8/23/2024, the resident presented as a risk for elopement. Further review of Resident #2's CP revealed the following intervention: place on walker's club and provide pictures to the first floor, second floor, and reception area (date initiated 8/23/2024).3. According to the AR, Resident #3 was admitted to the facility with diagnoses which included but were not limited to: Diabetes, Epilepsy (Seizures), and Major Depressive Disorder. According to the Quarterly MDS, an assessment tool dated 4/27/2025, Resident #1 had a BIMS score of 99, which indicated the resident was unable to complete the interview. The MDS also indicated that Resident #3 had an elopement alarm in place and was able to ambulate with supervision.According to Resident #3's CP with an initiated date of 8/1/2022, the resident presented as a risk for elopement. Further review of Resident #3's CP revealed the following intervention: place on walker's club and provide pictures to the first floor, second floor, and reception area (date initiated 8/11/2022).On 6/30/2025 at 2:15 PM, the surveyor interviewed the Activities Director (AD) at the receptionist desk. The AD stated she was covering the receptionist's break. The AD stated she believed that there were pictures of the wandering residents at the front desk but did not know where they were located. The AD further stated that there were resident pictures at the second-floor nursing station. On 6/30/2025 at 2:18 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #2) at the second-floor unit nursing station. LPN #2 stated No, we don't keep pictures of the residents who wander here at the nursing station. LPN #2 further stated he did not remember if any pictures had been previously kept at the nursing station.On 6/30/2025 at 2:23 PM, the surveyor interviewed LPN #4 at the first-floor nursing station. LPN #4 stated that the pictures of the wandering residents were usually kept on the wall at the nursing station. LPN #4 confirmed there were currently no pictures of the residents at the nursing station. She further stated, I believe they took it [pictures] down to update it, you have to ask the [DON].On 6/30/2025 at 2:50 PM, the surveyor interviewed the front desk Receptionist who stated that the pictures of the wanders were not kept at the front desk. She further stated that she knew who the wandering residents were and that the nurses kept her updated on who was a wanderer. On 6/30/2025 at 3:18 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA). The DON stated that the facility did not do the walker's club as indicated on the residents' care plans. The DON confirmed there were no pictures of the wandering residents at the nursing stations and the receptionist desk. The DON explained that the staff tell the receptionist who are the wandering residents. The DON stated, I confirm it is on the care plan about the walker's club, but we don't do that. The DON further stated that the MDS Coordinator was responsible for updating the care plans. The DON stated she did not know why the care plan intervention was not updated. NJAC 8:39-27.1 (a)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Complaint #: NJ187696Based on interviews, medical record review, and review of other pertinent facility documentation on 6/30/2025, it was determined that the facility nursing staff failed to consistently document on the Treatment Administration Record (TAR) the placement of a resident's wander guard bracelet (elopement device) according to the acceptable standards of nursing practice for 1 of 3 residents (Resident #3) reviewed for documentation. The facility also failed to follow its policy titled Documentation, Guidelines. This deficient practice 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 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.Reference: New Jersey Statutes Annotated Title 45. Chapter 11. New Jersey Board of Nursing Statutes 45:11-23. Definitions b. 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 regimens as prescribe by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human response means those signs, symptoms and processes which denote the individual's health need or reaction to an actual or potential health problem.According to the admission Record (AR), Resident #3 was admitted to the facility with diagnoses which included but were not limited to: Diabetes, Epilepsy (Seizures), and Major Depressive Disorder.According to the Quarterly Minimum Data Set (MDS), an assessment tool dated 4/27/2025, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident was unable to complete the interview. The MDS also indicated that Resident #3 had an elopement alarm in place.A review of the Order Summary Report (OSR) with active orders as of 6/30/2025 reflected a physician's order (PO) dated 2/25/2025 for Wander guard check placement to lower extremity every shift.A review of the Treatment Administration Record (TAR) for June 2025 reflected the corresponding PO for the wander guard with blank spaces for 6/12/2025 and 6/15/2025 on evening shift, and 6/24/2025 on day shift. On 6/30/2025 at 3:18 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA). The DON stated that the nursing staff were to check placement of the resident's wander guard every shift. She further explained that the nurses were to sign the physician's order out on the TAR after they complete the check. The DON confirmed that Resident #3 had blank spaces for the corresponding dates and shifts for the wander guard placement on the TAR. The DON indicated that the expectation was that the TAR was to be signed after the nurse checks for the wander guard and its functioning. Review of the undated facility policy titled, Documentation, Guidelines revealed under Guidelines for Documentation, 1. To chart in the medical record correctly. Under Essential Points, If it isn't charted, it didn't happen!NJAC 8:39-23.2 (a)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Complaint #: NJ187696Based on interviews, medical record review, and review of other pertinent facility documentation on 6/30/2025, it was determined that the facility failed to follow their protocol and policy to prevent the elopement of a severely cognitive impaired resident (Resident #1) who had a history of elopement from the facility when a Licensed Practical Nurse (LPN #1) heard the wander guard alarm sound at the front entrance of the facility and failed to respond to the alarm to ensure the safety of its residents. On 6/23/2025 at approximately 8:25PM, LPN #1 was coming down the stairs from the second-floor nursing unit when she heard the wander guard alarm at the front entrance sounding. She stated she called another staff member on the telephone to get the code to the keypad to stop the alarm. Once the LPN was given the code to the keypad, she turned the alarm off and proceeded to go on her break. LPN #1 stated she did not investigate why the wander guard alarm was going off. She further stated that she last saw Resident #1 in his/her room approximately 20 minutes before she heard the wander guard alarm sound. At 10:10 PM, the facility staff were notified by the local police by telephone that Resident #1 was found on a highway outside of the facility near a local ice cream shop. LPN #1 heard the wander guard alarm sound and failed to follow the facility's protocol which placed Resident #1 and all other residents at risk for elopement in an immediate jeopardy (IJ) situation. The IJ began on 6/23/2025, was identified on 6/30/2025 at 5:40 PM, and was reported to the Licensed Nursing Home Administrator (LNHA). The LNHA was presented with the IJ template at that time. An acceptable removal plan was electronically mailed to the surveyor on 7/1/2025 at 12:14 PM, indicating the facility's actions to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice. LPN #1 and all facility staff were re-educated on the facility's elopement protocol including the need to immediately respond when hearing the wander guard alarm sounding, checking the immediate area for any residents, and notifying the charge nurse who will then implement the elopement protocol. The surveyor verified the removal plan on site on 7/3/2025 and determined the IJ for F689 was removed as of 7/3/2025. After the IJ removal plan, the non-compliance continued from 7/3/2025 for no actual harm with the potential for more than minimal harm that is not an immediate jeopardy. This deficient practice was identified for 1 of 3 residents (Resident #1) reviewed and was evidenced by the following: According to the admission Record (AR), Resident #1 was admitted to the facility with diagnoses which included but were not limited to: Unspecified Convulsions, Unspecified Cerebral Infarction (Stroke), and Hypertension.According to the Quarterly Minimum Data Set (MDS), an assessment tool dated 6/5/2025, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated the resident's cognition was severely impaired. The MDS also indicated that Resident #1 had an elopement alarm in place. According to the Facility Reportable Event (FRE) dated 6/23/2025, Resident #1 eloped through a malfunctioning door. He/she was returned to the facility unharmed. The FRE also revealed that Resident #1 was a known elopement risk and had a care plan for elopement risk in place. Resident #1 wore a wander guard transmitter (elopement alarm). The surveyor reviewed Resident #1's nurses note (NN) dated 6/23/2025 at 10:10 PM. The NN revealed that the nurse received a phone call from the police stating Resident #1 was found walking on the highway near an ice cream shop. The police returned the resident to the facility. Further review of the NN indicated that the resident's wander guard to his/her arm was in place and the alarm sounded as the resident came through the door. According to Resident #1's Care Plan (CP) with a focus of risk for elopement initiated on 10/14/2024, and a revision date of 6/24/2025, the resident eloped from the building on 11/3/2024 and 6/23/2025. The CP further revealed that the resident was moved to the second floor on 11/3/2024. On 6/30/2025 at 10:08 AM, the surveyor interviewed LPN #2 who stated he was the nurse on duty when Resident#1 left the building. LPN #2 stated at approximately 10:00 PM, he went to Resident #1's room to give him/her medications and the resident was not in the room. LPN #2 further indicated I was preparing to go downstairs to get him/her, and the cop called. LPN #2 stated he did not know when the resident had left the unit. On 6/30/2025 at 10:31 AM, the surveyor conducted a follow-up interview with LPN #2 who stated he last saw Resident #1 after dinner, around 6:00 PM or 7:00 PM. LPN #2 continued to explain that Resident #1 did not need a staff member to go off the unit. LPN #2 indicated We don't always go room to room to check on them, but we see them. By 10:00 PM, they need to be on the floor. After 10:00 PM, no one can go downstairs.On 6/30/2025 at 2:39 PM, the surveyor interviewed LPN #1 who stated she was working the night Resident #1 left the facility. She further indicated It was around 8:25PM and I was going on my break. I was coming down the stairs and when I got to the second flight coming down, I heard