STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315338	A. BUILDING _____ B. WING _____	C 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWRENCE	**1 BISHOPS DRIVE LAWRENCEVILLE, NJ 08648**

(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 C# : NJ00176735 Census 158 Sample Size 4 The facility was in substantial compliance with the requirement of 42 CFR Part 483, Subpart B, for Long Term Care facilities based on this complaint visit.	F 000		

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

Electronically Signed | 10/25/2024

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
	031103	A. BUILDING: _____ B. WING _____	C 09/17/2024

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LAWRENCE REHAB & HCC/THE MEADOWS AT LAWR	1 BISHOPS DRIVE LAWRENCEVILLE, NJ 08648

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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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: C# NJ 24081 Based on interview and review of data provided by the facility, it was determined that the facility failed to ensure that there was appropriate licensed and certified staff and/or adequate staffing levels for 12 of 14 days. This deficient practice is evidenced by the following: 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 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	CORRECTIVE ACTION(S): • Lawrence enter is actively trying to hire CNAs . • "DON, staffing coordinator or designee will review staffing callouts daily and make every effort to replace. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE	9/18/24

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

Electronically Signed — 10/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. However, the Nurse Staffing Reports provided by the facility for the weeks of 9/1/2024 to 9/14/2024 revealed the following: The facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -09/01/24 had 10 CNAs for 109 residents on the day shift, required at least 14 CNAs. -09/02/24 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. -09/03/24 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. -09/04/24 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -09/05/24 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -09/06/24 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -09/07/24 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -09/08/24 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/09/24 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/10/24 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. -09/12/24 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -09/14/24 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs.	S 560	• All residents have the potential to be affected by this practice. MEASURES PUT IN PLACE: Facility's Recruitment and Retention Strategies and Efforts to comply with the State's Staffing Ratios have been in progress, which include but are not limited to the following: 1. Offer bonuses to attract staff. 2. Recruitment bonus to encourage referrals from current staff 3. Facility offers bonuses based on an established bonus plan for any extra shifts being picked up by a CNA. 4. Continue running ads in various social media platforms. 5. Increased Sponsorships of advertisements on social media platforms. 6. Flexible shifts and schedules 7. The facility implemented higher rates for C.N.A. 8. Nursing staff will assist in covering open C.N.A shifts when needed. MONITORING OF MEASURES: • Staffing Coordinator will provide weekly reports to the Director of Nursing and Administrator regarding all efforts made to try to comply with the State's Staffing Ratios. • Reports will be submitted to the QAPI Committee monthly X 3 months. • After 3 months QAPI Committee will review if any further changes have to be	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWR	1 BISHOPS DRIVE LAWRENCEVILLE, NJ 08648

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S 560	Continued From page 2	S 560	made.	
S2355	8:39-31.6(p)(1) Mandatory Physical Environment (p) The facility shall establish a written heat emergency action plan which specifies procedures to be followed in the event that the indoor air temperature is 82 degrees Fahrenheit or higher for a continuous period of four hours or longer. 1. These procedures shall include the immediate notification of the Department of Health and Senior Services. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, medical record review, and review of other pertinent facility documents on 9/17/2024, it was determined that the facility staff failed to report the breakdown of the cooling unit at the facility on 8/2/2024 to the New Jersey Department of Health. The surveyors entered the building on 9/17/24 at approximately 9:15 a.m., the Surveyors observed two Packaged Terminal Air Conditioners (PTAC) blowing cool air. According to one of the staff, the PTAC had been in place for awhile (unable to recall exact date). During the tour of the first floor on 9/17/24 at	S2355	CORRECTIVE ACTION(S): 1. The current administrator reported the HVAC unit failure to LTCO and NJDOH. 2. An audit was conducted of physical environment /services for the last 30 days to validate that any change affecting physical environment leading to interruption of service were reported to the NJDOH and thoroughly investigated as required. With no findings. 3. The Regional Director of Operations re-educated the Administrator and the DON on reporting requirements IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE	9/18/24

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S2355	Continued From page 3 10:12 a.m., the Surveyors observed 2 PTAC blowing cool air. Review of the "Temporary Hallway Air Temperatures" (THAT) revealed the following The First Floor Center (FFC); On 8/2/24, from 12:30 p.m. to 2:30 p.m. the temperature (T) was from 84 degrees (D) to 85 D On 8/5/24, from 10:30 a.m. to 3:30 p.m. the T was from 84 to 85 D. On 8/6/24, from 7:30 a.m. to 3:30 p.m. the T was from 83 to 87 D. On 8/7/24, from 7:30 a.m. to 3:30 p.m. the T was from 84 to 88 D. On 8/8/24, from 7:30 a.m. to 3:30 p.m. the T was from 83 to 84 D. The Second Floor Center (SFC); On 8/2/24, from 7:30 a.m. to 3:30 p.m. the T was from 84 to 89 D. On 8/3/24, from 10:30 a.m. to 3:30 p.m. the T was from 85 to 87 D. On 8/4/24, from 7:30 a.m. to 3:30 p.m. the T was from 83 to 86 D. On 8/5/24, from 7:30 a.m. to 3:30 p.m. the T was from 84 to 89 D. On 8/6/24, from 7:30 a.m. to 3:30 p.m. the T was from 86 to 89 D. On 8/7/24, from 7:30 a.m. to 3:30 p.m. the T was from 86 to 87 D. On 8/8/24, from 7:30 a.m. to 3:30 p.m. the T was from 86 to 88 D. On 9/10/24, from 7:30 a.m. to 3:30 p.m. the T was from 83 to 85 D. On 9/11/24, from 1:30 p.m. to 3:30 p.m. the T was from 83 to 84 D. On 9/12/24, from 8:30 a.m. to 3:30 p.m. the T was from 83 to 85 D. On 9/13/24, from 10:30 a.m. to 3:30 p.m. the T	S2355	AFFECTED BY THE SAME DEFICIENT PRACTICE All residents have potential to be affected by this practice. MEASURES PUT IN PLACE: 4. The Administrator/Designee will complete a review of 5 grievances and all items on TELS to validate that any change affecting physical environment leading to interruption of service were reported to the NJDOH. MONITORING OF MEASURES: Above audits will be completed weekly for four weeks and then monthly for two months. Variances will be addressed. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly x three months for further review and recommendations as needed. Further audit frequency will be determined based on the outcome of the previously completed audit findings.	

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S2355	Continued From page 4	S2355		

was from 83 to 85 D.
On 9/17/24, from 7:30 a.m. to 9:30 a.m. the T was 84 D.

During the Surveyors interview with the Maintenance Director (MD) on 9/17/24 at 11:25 a.m., he stated that the central air conditioning unit broke down sometimes early August (unable to recall exact time and have placed the PTAC system in the building. The MD further stated that both floors (first and seconds floor) the residents room air conditioning units were not affected. The MD stated that the older unit was beyond repair and unit had to be ordered which was approved and delivery was 16 weeks away as of the date of survey (9/17/2024). An invoice for the order was presented dated 8/16/2024.

During the Surveyors interview with the Administrator on 9/17/24 at 11:36 a.m., she stated that she was aware that the central air conditioning was not working and was not aware that event needed to be reported to NJDOH.

During interview with the residents on the unit on 9/17/2024, they stated they were comfortable and stated they had no complaints with the temperature on that wing (Second Floor hallway).

The undated facility policy titled "SECTION E: EMERGENCY PROCEDURES FOR SPECIFIC EVENTS," under "LOSS OF AIR CONDITIONING/HIGH HEAT...INCIDENT COMMAND (ADMINISTRATOR OR PERSON IN CHARGE AT TIME)...Determine need to report situation to State or other regulatory agency..."

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
031103		10/25/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWRENCE	1 BISHOPS DRIVE LAWRENCEVILLE, NJ 08648

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 09/18/2024	ID Prefix S2355 Reg. # 8:39-31.6(p)(1) LSC	Correction Completed 09/18/2024	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
9/17/2024

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