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 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWR	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) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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: Complaint #: NJ154829; NJ157523; NJ167771; NJ168132; NJ169996; NJ172438 Based on interview and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 55 out of 77 day shifts and 1 out of 105 evening shifts; and 1 of 77 overnight shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	No residents were identified as having been affected. All residents have the potential to be affected. Actions to correct the deficiency -Director of Nursing, Staffing Coordinator and Administrator will meet daily during the week to review recruitment efforts, staffing for next day, and staffing for upcoming week. Trends identified from these meeting will be presented during monthly QAPI meeting. -The facility has implemented a	4/12/24

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

Electronically Signed | 04/26/24

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 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWR	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) COMPLETE DATE
S 560	Continued From page 1 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 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. During entrance conference on 3/27/24 10:28 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) how the facility's staff was, and the LNHA stated that weekday staffing was good, and sometime Sunday staffing could be low. The LNHA stated the facility utilized agency staff as needed for coverage. At this time, the surveyor requested the Nurse Staffing Report to be completed for the following weeks: 4/16/23 to 4/29/23; 8/6/23 to 8/26/23; 9/17/23 to 10/7/23; 1/7/24 to 1/20/24; 2/11/24 to 3/2/24; 3/10/24 to 3/23/24. The surveyor reviewed the facility completed Nurse Staffing Reports which revealed the	S 560	multifaceted approach for recruitment and retention of employees, which includes Job fairs, Flexible scheduling, Increased utilization of PRN/Per diem staff (Staff hired without any set hours, usually staff who have another job and pickup extra shifts when the need arises),Implementation of advanced staffing management software system, Multimedia advertisements, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Boomerang campaign to rehire staff that have resigned, Rate adjustments, Benefit adjustments, Text message campaigns. -The facility has hired and continues to hire unlicensed staff for the position of Caring Partner" with duties of providing assistance to aides with tasks that do not require certification. The facility then pays for these staff to go to CNA school and become certified nurse aides employed by the facility. -The facility has developed a Culture Committee focused on recruitment and codified retention of staff by enhancing the employee experience, some of the committees activities include a weekly event for staff where food is provided, as well as bi-monthly large fun event with food and prizes with 2 employees of the Month chosen. The facility also has seasonal holiday parties, gives all employees presents during each holiday season and celebrates all employee's birthday's once a month. --The facility has implemented the Care	

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 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWR	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) COMPLETE DATE
S 560	Continued From page 2 following: 1. For the two weeks of Complaint staffing at the Main Building from 4/16/23 to 4/29/23, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: 4/16/23 had 15 CNAs for 138 residents on the day shift, required at least 17 CNAs. 4/21/23 had 17 CNAs for 141 residents on the day shift, required at least 18 CNAs. 4/23/23 had 15 CNAs for 141 residents on the day shift, required at least 18 CNAs. 2. For the three weeks of Complaint staffing at the Main Building from 8/6/23 to 8/26/23, the facility was deficient in CNA staffing for residents on 15 of 21 day shifts as follows: 8/6/23 had 15 CNAs for 151 residents on the day shift, required at least 19 CNAs. 8/7/23 had 17 CNAs for 151 residents on the day shift, required at least 19 CNAs. 8/8/23 had 18 CNAs for 151 residents on the day shift, required at least 19 CNAs. 8/10/23 had 17 CNAs for 149 residents on the day shift, required at least 19 CNAs. 8/11/23 had 17 CNAs for 149 residents on the day shift, required at least 19 CNAs. 8/12/23 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs. 8/13/23 had 17 CNAs for 150 residents on the day shift, required at least 19 CNAs. 8/15/23 had 16 CNAs for 146 residents on the day shift, required at least 18 CNAs. 8/17/23 had 16 CNAs for 144 residents on the day shift, required at least 18 CNAs. 8/18/23 had 15 CNAs for 144 residents on the day shift, required at least 18 CNAs.	S 560	Champion Program to mentor new employees where the champions/mentors (senior CNA staff) receive a bonus if the new employee stays for a certain period of time. -The facility participates in a weekly interdisciplinary Quality Care Resource call with consultants to review open positions, recruitment tactics, and changes to improve outcomes. -The facility has implemented processes to increase communication with employees through monthly Townhall meetings and Digital Suggestion Box. -The facility conducts an exit meeting with any employee who resigns to better improve the employee experience and help with retention. Monitoring -Administrator/designee will review the minutes from the daily staffing meeting to determine whether all efforts are resulting in staffing levels meeting the requirements. Daily for 4 weeks for a month. and bi-weekly for 2 more months. -Administrator/designee will interview five residents weekly for 4 weeks and then monthly for an additional 2 months to determine if needs are being met. -The results of the audit will be reported to the facility QAPI Committee for one quarter to determine if sufficient compliance has been met. Based on the	

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 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWR	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) COMPLETE DATE
S 560	Continued From page 3 8/19/23 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs. 8/20/23 had 15 CNAs for 147 residents on the day shift, required at least 18 CNAs. 8/21/23 had 17 CNAs for 147 residents on the day shift, required at least 18 CNAs. 8/22/23 had 17 CNAs for 147 residents on the day shift, required at least 18 CNAs. 8/26/23 had 15 CNAs for 147 residents on the day shift, required at least 18 CNAs. 3. For the three weeks of Complaint staffing at the Main Building from 9/17/23 to 10/7/23, the facility was deficient in CNA staffing for residents on 16 of 21 day shifts as follows: 9/17/23 had 17 CNAs for 151 residents on the day shift, required at least 19 CNAs. 9/18/23 had 17 CNAs for 149 residents on the day shift, required at least 19 CNAs. 9/19/23 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs. 9/21/23 had 14 CNAs for 149 residents on the day shift, required at least 19 CNAs. 9/22/23 had 14 CNAs for 149 residents on the day shift, required at least 19 CNAs. 9/23/23 had 15 CNAs for 149 residents on the day shift, required at least 19 CNAs. 9/24/23 had 15 CNAs for 152 residents on the day shift, required at least 19 CNAs. 9/25/23 had 17 CNAs for 152 residents on the day shift, required at least 19 CNAs. 9/26/23 had 15 CNAs for 151 residents on the day shift, required at least 19 CNAs. 9/28/23 had 16 CNAs for 151 residents on the day shift, required at least 19 CNAs. 9/29/23 had 16 CNAs for 151 residents on the day shift, required at least 19 CNAs.	S 560	results of the audit the QAPI committee will determine continued need for the audit.	

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 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWR	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) COMPLETE DATE
S 560	Continued From page 4 9/30/23 had 17 CNAs for 150 residents on the day shift, required at least 19 CNAs. 10/1/23 had 16 CNAs for 150 residents on the day shift, required at least 19 CNAs. 10/2/23 had 17 CNAs for 149 residents on the day shift, required at least 19 CNAs. 10/3/23 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs. 10/7/23 had 16 CNAs for 147 residents on the day shift, required at least 18 CNAs. 4. For the two weeks of Complaint staffing at the Main Building from 1/7/24 to 1/20/24, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 evening shifts as follows: 1/7/24 had 8 CNAs for 100 residents on the day shift, required at least 12 CNAs. 1/8/24 had 7 CNAs for 99 residents on the day shift, required at least 12 CNAs. 1/9/24 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. 1/10/24 had 8 CNAs for 99 residents on the day shift, required at least 12 CNAs. 1/11/24 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. 1/12/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. 1/13/24 had 8 CNAs for 106 residents on the day shift, required at least 13 CNAs. 1/14/24 had 6 CNAs for 106 residents on the day shift, required at least 13 CNAs. 1/15/24 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. 1/16/24 had 9 CNAs for 106 residents on the day shift, required at least 13 CNAs. 1/16/24 had 8 total staff for 106 residents on the	S 560		

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 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWR	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) COMPLETE DATE
S 560	Continued From page 5	S 560		

evening shift, required at least 11 total staff.
1/17/24 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs.
1/18/24 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs.
1/19/24 had 7 CNAs for 110 residents on the day shift, required at least 14 CNAs.
1/20/24 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs.

5. For the one week of Complaint staffing for the Main Building from 2/11/24 to 2/17/24, the facility was deficient in CNA staffing for residents on 7 of 7 day as follows:

2/11/24 had 8 CNAs for 111 residents on the day shift, required at least 14 CNAs.
2/12/24 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs.
2/13/24 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs.
2/14/24 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs.
2/15/24 had 9 CNAs for 115 residents on the day shift, required at least 14 CNAs.
2/16/24 had 8 CNAs for 115 residents on the day shift, required at least 14 CNAs.
2/17/24 had 9 CNAs for 113 residents on the day shift, required at least 14 CNAs.

On 4/8/24 at 9:35 AM, the surveyor interviewed the Staffing Coordinator who stated she scheduled one CNA to every eight residents during the day shift; one CNA to every ten residents during the evening shift; and one CNA for every fourteen residents during the overnight shift. The Staffing Coordinator stated the facility fell short of the required ratios if there were callouts, but the facility used agency staff and

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 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWR	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) COMPLETE DATE
S 560	Continued From page 6 asked their staff to cover shifts.	S 560		

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 04/09/2024

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 Complaint #: NJ154829; NJ157523; NJ165827; NJ167771; NJ167946; NJ168132; NJ168684; NJ169765; NJ169996; NJ172438 Survey Date: 4/9/24 Census: 161 Sample: 34 + 3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the call bell within reach of the resident. This deficient practice was identified for 1 of 32 residents reviewed for accommodation of needs (Resident #89), and was evidenced by the following: On 3/27/24 at 12:09 PM, the surveyor observed Resident #89 in their room, seated in a wheelchair with their eyes closed. The surveyor observed the resident's call bell (a bell used to	F 558	CORRECTIVE ACTION(S): 1. Resident #89□s call bell was applied within the resident□s reach. Rounds were conducted on Resident #89 to validate that call bells were within reach by the Unit Managers on 4/10/24 and 4/11/24. No further variances were noted. 2. Rounds were conducted on current residents to validate that call bells were within reach by the Director of Nurses/ designee on 4/10/24 and 4/11/24. No further variances were noted.	4/12/24

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

Electronically Signed | 04/26/2024

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 04/09/2024

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 558	Continued From page 1 summon staff for assistance) was on the floor, not within his/her reach. On 3/27/24 at 12:17 PM, the surveyor observed Resident #89 in his/her room seated in a wheelchair with their call bell located on the floor, not within his/her reach. On 4/4/24 at 1:18 PM, the surveyor observed Resident #89 in his/her room seated in a wheelchair eating their lunch meal. The surveyor observed the call bell was positioned in the middle of the resident's bed; not within their reach. The surveyor asked the resident how he/she called the staff when they needed assistance, and the resident pointed to the call bell and stated that he/she would "hit the buzzer". The resident then reached out his/her arms and stated, "I have long arms, but not that long." On 4/4/24 at 1:25 PM, the surveyor interviewed the Certified Nursing Aide (CNA) who stated the resident used their call bell to alert staff they needed assistance. At that time, the surveyor accompanied by the CNA and the Licensed Practical Nurse (LPN) entered Resident #89's room, and they observed the call bell in the middle of the resident's bed, not within the resident's reach. The CNA and LPN acknowledged the call bell should have been left within the resident's reach and proceeded to place it within reach. The surveyor reviewed the medical record for Resident #89. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which	F 558	IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE " All residents have the potential to be affected. MEASURES PUT IN PLACE Nursing staff were educated by the Director of Nurses/designee on on call bell placement. MONITORING OF MEASURES: 4. The Director of Nursing /Designee will complete 5 random audits for call bell placement. Rounds will be completed weekly for four weeks 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.	

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 04/09/2024

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 558	Continued From page 2 included a history of NJ EX Order. 264b1 . A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, reflected the resident had a brief interview for mental status score of NJ EX Order. 264b1 which indicated a NJ EX Order. 264b1 . A further review indicated they required NJ EX Order. 264b1 from staff for transfers and toileting. A review of the individual comprehensive care plan included a focus area dated NJ EX Order. 26, I am at NJ EX Order. 264b1 . Interventions included keeping the call [bell] within reach and providing reminders to use it to call for assistance. On 4/8/24 at 10:18 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the Director of Nursing (DON), Regional LNHA, and survey team acknowledged that all residents should have their call bells within reach, and confirmed that the staff member who set the resident up with their lunch tray should have ensured the call bell was within reach. A review of the facility's Certified Nursing Assistant job description included ...the primary purpose of your job position is to provide each of your assigned residents with routine daily nursing care and services ...which included keeping the nurses' call system within easy reach of the resident.	F 558		
F 609 SS=D	NJAC 8:39- 31.8 (c)(9) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		4/26/24

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 04/09/2024

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 609	Continued From page 3 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint # NJ169996; NJ172438 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to report an alleged theft (wedding ring) to the New Jersey Department of Health (NJDOH). This deficient practice was identified for 1 of 4 residents reviewed for abuse (Resident	F 609	1. The Administrator reported Resident #35□s allegation of theft to the NJDOH and a thorough investigation was completed. 2. All residents have a potential to be affected. An audit was conducted of grievances for the last 30 days to validate that	

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 04/09/2024

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 609	Continued From page 4 # 35), and was evidenced by the following: According to Resident #35's Admission Record face sheet (an admission summary), the resident was admitted to the facility with diagnoses which included unspecified [redacted] According to the most recent quarterly Minimum Data Set (MDS), an assessment tool, Resident #35 had a brief interview for mental status (BIMS) score of [redacted], which indicated a [redacted]. The MDS further indicated the resident was dependent on staff for Activities of Daily Living (ADL). A review of the facility provided "Grievance Summaries" included an incident date of [redacted], "reported date of [redacted] and a "resolved date of [redacted] which was completed by the Director of Nursing (DON), included a missing [redacted] reported to facility [redacted] and the police report filed in December. This was reported to the facility at least a month after the occurrence at which point the family was explained it "would difficult to follow-up on; family upset". Summary of Actions Taken included, resident's [representative] decided to report to the local police. The grievance did not include documentation that the NJDOH was notified of the alleged theft. On 4/3/24 at 9:36 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated the previous Administrator was in charge of this grievance and they were aware of the missing [redacted]. The LNHA	F 609	allegations of abuse, neglect or misappropriation were reported to the NJDOH and thoroughly investigated. 3. The Regional Director of Operations re-educated the Administrator and the Director of Nursing on the policy for abuse, neglect and misappropriation reporting and investigating. 4. The Administrator/Designee will complete a review of 5 grievances to validate that allegations of abuse, neglect, or misappropriation were reported to the NJDOH and thoroughly investigated. These 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.	

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 04/09/2024

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 609	Continued From page 5 stated the incident was not reported to the NJDOH and acknowledged that it should have been. A review of facility provided policy titled "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating" with a revised date of September 2022, included if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility... A review of an undated facility provided policy titled "Investigating Incident of theft and/or Misappropriation of Resident Property" included...if an alleged or suspected case of the theft, exploitation or misappropriation of resident property is reported, the facility administrator, or his/her designee, notifies the following persons or agencies within twenty-four (24) hours of such incident, as appropriate: a. State licensing and certification agency...	F 609		
F 610 SS=D	NJAC 8:39-4.1(a)15 Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 610		4/26/24

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 04/09/2024

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 610	Continued From page 6 must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #NJ 169996; NJ172438 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to complete a thorough investigation for an alleged theft NJ EX Order. 264b1 for 1 of 4 residents reviewed for abuse (Resident #35). This deficient practice was evidenced by the following: According to Resident #35's Admission Record face sheet (an admission summary), the resident was admitted to the facility with diagnoses which included NJ EX Order. 264b1 According to the most recent quarterly Minimum Data Set (MDS), an assessment tool, Resident #35 had a brief interview for mental status (BIMS) score of NJ EX Order. 264b1, which indicated a NJ EX Order. 264b1. The MDS documentation also identified that Resident #35 is dependent on staff	F 610	1. The Administrator reported Resident #35□s allegation of theft to the NJDOH and a thorough investigation was completed. 2. All residents have the potential to be affected. An audit was conducted of grievances for the last 30 days to validate that allegations of abuse, neglect or misappropriation were reported to the NJDOH and thoroughly investigated. 3. The Regional Director of Operations re-educated the Administrator and the Director of Nursing on the policy for abuse, neglect and misappropriation reporting and investigating. 4. The Administrator/Designee will complete a review of 5 grievances to validate that allegations of abuse, neglect or misappropriation were reported to the NJDOH and thoroughly investigated.	

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 04/09/2024

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 610	Continued From page 7 for Activities of Daily Living (ADL). A review of the facility provided "Grievance Summaries" included an incident date of [redacted], "reported date of [redacted]", and a "resolved date of [redacted]" which was completed by the Director of Nursing (DON) included a missing ring reported to facility 10/26/23 and the police report filed in December. Summary of Investigation included resident's [representative] had no explanation when asked why [he/she] did not report missing item immediately. Summary of Findings included difficult to investigate due to time lapse in reporting. Summary of Actions Taken included resident's [representative] decided to report to the local police. On 4/2/24 at 11:30 AM, the surveyor interviewed the Director of Nursing (DON) who stated they were unaware if the previous Administrator had completed an investigation or if there were any statements from staff written. The surveyor asked if incident should have been investigated, the DON replied, "it was hard to investigate, due to being reported a month later." On 4/8/24 at 10:17 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON, Regional LNHA, and survey team stated they were aware that the resident lost a wedding ring but the previous Administrator was at the facility at the time. The LNHA acknowledged the incident should have been investigated. A review of the undated facility provided policy titled "Investigating Incident of theft and/or Misappropriation of Resident Property"	F 610	These 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.	

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 04/09/2024

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 610	Continued From page 8 included...when an incident of theft and/or misappropriation of resident property is reported, the administrator appoints a staff member to investigate the incident... A review of facility provided policy titled "Abuse, Neglect, Exploitation or Misappropriation-Reporting and investigating" with a revised date of September 2022, included all allegations are thoroughly investigated. The administrator initiates investigations... NJAC 8:39-5.1(a)	F 610		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure an electronic pharmacy drug interaction alert was communicated to a physician in accordance with professional standards of practice. This deficient practice was identified for 1 of 30 residents reviewed for professional standards of practice (Resident #450). 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 registered professional nurse is defined as diagnosing and	F 658	1. Resident #450 no longer resides at the facility. 2. All residents on antibiotics the potential to be affected. An audit was completed by the Director of Nurses/ designee on current residents on [redacted] to validate electronic pharmacy drug interaction alerts were reviewed with the physician and progress notes to include provider guidance. Variances were addressed and recorded on the facility audit tool. 3. Licensed Nurses were re-educated on the electronic pharmacy drug interaction alert policy with physician notification and	4/12/24

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 04/09/2024

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 658	Continued From page 9 treating human responses to actual and 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 prescribed by a licensed or otherwise legally authorized physician or dentist." 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." This deficient practice was evidenced by the following: On 3/27/24 at 12:12 PM, the surveyor observed Resident #450 lying in bed with a NJ EX Order. 264b1 (NJ EX Order. 264b1 The resident stated that he/she had a NJ EX Order. 264b1 in their and they were leaving for doctors appointment. The surveyor reviewed the medical record for Resident #450. A review of the Admission Record face sheet (an admission summary) reflected that the resident	F 658	progress note. 4. The Director of Nursing /Designee will complete a review of 5 current residents on Antibiotics to validate that electronic pharmacy drug interaction alerts were addressed per policy. Variances will be addressed. These 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.	

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 04/09/2024

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 658	Continued From page 10	F 658		

was admitted to the facility with diagnoses which included NJ EX Order. 264b1 and NJ EX Order. 264b1).

A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, reflected that the resident had a brief interview for mental status (BIMS) score of NJ EX Order. 264b1 indicating a NJ EX Order. 264b1 .

A review of the Progress included a Physician's Order Note dated NJ EX Order. 26 at 11:11 PM, included the order you have entered NJ EX Order. oral capsule NJ EX Or milligram (mg), an NJ EX Order. 264b1 , give one capsule by mouth every NJ EX Order. 26 hours for NJ EX Order. 2 for NJ EX O days; has triggered a drug to drug interaction. The system has identified a possible drug interaction with the NJ EX Order. 264b1 oral tablet order.

A review of the corresponding NJ EX Order. 264b1 Medication Administration Record, revealed NJ EX Order. and the NJ EX Order. 264b1 were scheduled to be administered at 9:00 AM.

A further review of the Progress Notes did not include the physician was made aware of the possible drug interaction.

On 4/4/24 at 11:28 AM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that when a physician order was inputted into the electronic medical record, the Pharmacy will automatically generate a drug interaction alert that the facility was responsible to address. The CP stated NJ EX Order. interacted with the NJ EX Or in the NJ EX Order. 264b1 which affected the absorption of the

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 04/09/2024

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 658		F 658		

Continued From page 11

NJ EX Order. 264b1).

On 4/4/24 at 1:05 PM, the surveyor interviewed the Registered Nurse (RN) who stated when a drug interaction was identified, the nurses called the physician to inform them, and the physician determined how to proceed. The nurse then documented in the Progress Notes that they spoke to the physician, and how the physician wanted to proceed. At this time the surveyor and the RN observed the facility's house stock NJ EX Order. 264b1 bulk bottle which contained iron as one of the NJ EX Order. 264b1

On 4/4/24 at 1:10 PM, the surveyor interviewed the Unit Manger/Licensed Practical Nurse (UM/LPN) who confirmed the nurse notified the physician of any drug interactions, and documented the notification with any new orders. The UM/LPN acknowledged NJ EX Order 2 should not be administered at the same time as the NJ EX Order. 264b1 NJ EX Order. 264b1, and that the physician was never notified.

On 4/8/24 at 10:00 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON), Regional LNHA, and survey team confirmed the nurses should be contacting the physician at the time a pharmacy drug interaction alert was generated, and document the notification in the Progress Notes. The LNHA acknowledged the physician was not notified of the interaction between the NJ EX Order 2 and NJ EX Order. 264b1 until surveyor inquiry.

A review of the facility's "Medication and Treatment Orders" policy dated revised July 2016, did not include a procedure for pharmacy drug interaction alerts.

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 04/09/2024

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 658	Continued From page 12 NJAC 8:39-27.1(a)	F 658		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint#: NJ167771; NJ168132 Based on observation, interview, and review of pertinent facility documentation, it was	F 725	1. Resident #57 was reviewed with no indication of an adverse effect related to the cited occurrence. Rounds were completed on 4/10 and 4/11 by the	4/12/24

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 04/09/2024

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 725	Continued From page 13 determined that the facility failed to provide sufficient nursing staff to ensure activities of daily living (ADLs) including NJ EX Order. 264b1 care and assistance NJ EX Order. 264b1 were performed for a resident. This deficient practice was identified on 1 of 30 residents reviewed for sufficient staffing (Resident #57), and was evidenced by the following: On 4/1/24 at 11:58 AM, the surveyor observed Resident #57 awake in bed with their untouched breakfast tray on their overbed table. At this time, the surveyor requested from the Unit Clerk a copy of the Certified Nursing Aide (CNA) assignment sheet for that day. A review of the assignment sheet revealed the Registered Nurse (RN) was scheduled and assigned as Resident #57's CNA for the 7:00 AM to 3:00 PM (7-3) shift. On 4/1/24 at 12:00 PM, the surveyor interviewed the RN who confirmed that they were scheduled as a CNA for the care of Resident #57. The surveyor asked if the resident ate breakfast that morning or received their morning care. The RN responded that they had not yet assisted the resident with their breakfast or performed NJ EX Order. 264b1 care for that shift. The RN stated they had fifteen assigned residents for the day and still needed to provide care for Resident #57. The RN confirmed that the resident received nutrition through an NJ EX Order. 264b1) but also received regular meals that the resident needed NJ EX Order. 264b1 On 4/1/24 at 12:01 PM, the surveyor in the presence of the RN requested the Unit Manager/Licensed Practical Nurse (UM/LPN) to accompany them to Resident #57's room. The	F 725	Director of Nursing/designee with Resident #57 assisted NJ EX Order. 264b1. The identified RN was re-educated by the Director of Nursing/designee on providing incontinence care and meal assistance and to request assistance as needed. 2. All residents have the potential to be affected. Assignments were reviewed by the Administrator and Staffing Coordinator to validate staffing needs. Variances were addressed and recorded on the facility audit tool. 3. The Staffing Coordinator was re-educated by administrator on the policy for staffing and communication when variances are identified. 4. The Administrator/designee will conduct 3 reviews of the staffing schedule and make rounds to validate that staffing, delivery of care and services including NJ EX Order. 264b1 care and assistance with NJ EX Order. 2 Variances will be addressed. 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.	

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 04/09/2024

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 725	Continued From page 14	F 725		

surveyor asked the UM/LPN to check if the resident's NJ EX Order. 264b1, and the UM/LPN confirmed the NJ EX Order. 264b1 with NJ EX Order and needed to be changed. At this time, the surveyor asked the UM/LPN if the the resident had been assisted with breakfast that morning. The UM/LPN confirmed the breakfast tray was untouched and the resident still needed to eat. The UM/LPN stated the breakfast tray was delivered around 8:30 AM.

The surveyor reviewed the CNA assignment sheet for the 7-3 shift on 4/1/24, which revealed the census for the nursing unit was NJ EX Or and there were four assigned CNAs for the residents. The RN who was assigned as a CNA had fifteen residents on her assignment for the day.

The surveyor then reviewed the medical record of Resident #57.

A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included NJ EX Order. 264b1

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, reflected the resident had NJ EX Order. 264b1. A further review revealed the resident received more than NJ EX Orde of their NJ EX Order. 264b1 NJ EX Or, NJ EX Order 2 and NJ EX Order. 264.

A review of the individualized comprehensive care

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 04/09/2024

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 725	Continued From page 15	F 725		

plan (ICCP) dated effective [redacted], included a focus area that the resident was at [redacted] in regards to his/her varying by [redacted]. Interventions included to provide me with a diet as ordered [redacted]; monitor intake and tolerance; monitor for changes in [redacted]. An additional focus area included Activities of Daily Living (ADL) self-care performance with interventions that included to provide hands-on-assistance for [redacted], and [redacted]

A review of a Nutrition Note dated [redacted] at 11:50 AM, the resident received a [redacted] with [redacted] liquids and no concerns with weight were identified.

A review of the CNA tasks included eating and nutrition required hand-on assistance for [redacted] and [redacted] with [redacted] with [redacted] and [redacted] The tasks also included for toileting to check resident approximately every two hours and provide [redacted] care as needed.

On 4/3/24 at 11:18 AM, the surveyor interviewed the Director of Nursing (DON) who stated the CNAs began morning care around 7:30 AM, and morning care should be completed by 11:00/11:30 AM. The DON stated the CNAs also conducted rounds to ensure residents [redacted] were changed every two hours. The DON stated there should be one CNA assigned to eight residents for the 7-3 shift.

On 4/8/24 at 10:17 AM, the DON in the presence Licensed Nursing Home Administrator (LNHA), Regional LNHA, and survey team acknowledged it was not acceptable that the resident was not

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 04/09/2024

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 725	Continued From page 16 seen by the CNA that morning; the resident should have been fed NJ EX Order. 264b1 and received NJ EX Order. 264 care before 12:00 PM. A review of the facility's "Activities of Daily Living (ADLs), supporting policy dated revised March 2018, included resident will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living... A review of the facility's "NJ EX Order. 264b1 and NJ EX Order. 264b1 -Assessment and Management" policy dated August 2022, included the physician and staff will provide appropriate services and treatment to help residents restore or improve NJ EX Order. 264b1 and prevent NJ EX Order. 264b1 infections to the extent possible... NJAC 8:39-5.1(a)	F 725		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to complete performance review of Certified Nurse Aides (CNA) at least every twelve months and provide regular in-service education based on the outcome of these reviews. The	F 730	1. No specific residents were identified. Performance evaluations and in-service education based on the outcome of reviews were completed for Nursing Assistant #1, #2, #3, #4, and #5 by the Director of Nurses.	4/12/24

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 04/09/2024

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 730	Continued From page 17 deficient practice was identified for 5 of 5 CNAs (CNA #1; #2; #3; #4; and #5) reviewed for performance evaluations and was evidenced by the following: On 4/3/24 at 10:01 AM, the Licensed Nursing Home Administrator (LNHA) provided the surveyor with five randomly selected CNA employees' education for 2023. The LNHA stated that she could not locate the CNAs' employee performance reviews for 2023. The LNHA stated that the facility took ownership of the building in [redacted] of [redacted] and were starting to complete performance reviews now. A review of the education revealed: CNA#1: date of hire [redacted]; no performance review for 2022 or 2023; most recent performance review 4/1/24 CNA #2: date of hire [redacted]; no performance review 2022 or 2023; last performance review 2/17/24 CNA #3: date of hire [redacted] no performance review 2023; last performance review 2/7/24 CNA #4: date of hire [redacted]; no performance review 2022 or 2023; last performance review 3/30/24 CNA #5: date of hire [redacted] no performance review 2022 or 2023; last performance review 2/6/24 On 4/4/24 at 9:43 AM, the LNHA informed the surveyor that the facility had no performance reviews for 2023 and acknowledged that CNAs should have an annual review that was stored in their employee file. The LNHA stated that the facility started this year reviewing the CNAs, and all the CNAs have not been reviewed.	F 730	2. All residents have the potential to be affected. The Director of Nursing validated current Nursing Assistant staff are scheduled based on their anniversary date for performance reviews and education as indicated. 3. The Human Resources Director and the Director of Nurses were re-educated by the Administrator on the policy for performance review completion and in-service education. 4. The Administrator/designee will conduct 3 reviews of Nursing Assistant files around the employee anniversary date to validate that performance reviews have been completed and include in-service education based on the outcome of review. Variances will be addressed. 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.	

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 04/09/2024

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 730	Continued From page 18 On 4/5/24 at 9:19 AM, the surveyor interviewed the Human Recourses Director who confirmed CNAs should have performance evaluations completed yearly. On 4/8/24 at 10:17 AM, the LNHA in the presence of the Director of Nursing (DON), Regional LNHA, and survey team who acknowledged CNAs needed annual performance reviews to determine any additional inservices and education they needed for improvement. A review of an undated facility provided policy titled "Performance Evaluations" included the job performance of each employee shall be reviewed and evaluated at least annually. A performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter. The performance evaluation meeting will occur at the same time as the employee's compensation review...	F 730		
F 806 SS=D	NJAC 8:39-43.17(b) Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;	F 806		4/12/24

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 04/09/2024

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 806	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident's food preference of no gravy on meals was honored. This deficient practice was identified for 1 of 5 residents reviewed for nutrition (Resident #27), and was evidenced by the following: On 3/27/24 at 12:41 PM, the surveyor interviewed Resident #27 who stated they disliked gravy on his/her food because it NJ EX Order. 264b1. The resident stated they informed the Registered Dietitian (RD) their concern, but they still received gravy on his/her dinner meal every night. The surveyor then reviewed the medical record of Resident #27. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses that included NJ EX Order. 264b1). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, reflected that the resident had a brief interview for mental status (BIMS) score of NJ EX Order. 264b1, which indicated a NJ EX Order. 264b1. A review of the individualized comprehensive care plan (ICCP) dated effective NJ EX Order., included a focus area that the resident had a nutritional problem. Interventions included my food preferences will be recorded and updated as needed.	F 806	1. Resident #27□s food preferences were obtained by the Registered Dietitian with kitchen notification and documentation completed. 2. All residents have the potential to be affected. Current resident food preferences and food committee meeting notes for the last 30 days were reviewed by the Registered Dietitian to validate that kitchen notifications and documentation are in place for meal preferences. Variances were addressed and recorded on the facility audit tool. 3. The Registered Dietitian was re-educated by the Administrator on the policy for meal preference communication to the kitchen and documentation. 4. The Social Worker /designee will conduct 3 resident interviews to validate meal preferences. Variances will be addressed. 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.	

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 04/09/2024

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 806	Continued From page 20 A review of the Admission Nutrition Assessment dated effective [redacted], included the resident received a therapeutic diet (such as [redacted] NJ EX Order. 264b1), and had no dietary preferences. A review of the Progress Notes did not include any Dietary/Nutrition Notes with the resident's dietary preferences. On 4/1/24 at 12:30 PM, the surveyor observed Resident #27 in their room eating lunch which consisted of soup, apple pie and iced tea. The surveyor reviewed the resident's lunch Selection Sheet (meal ticket) which indicated no preferences or dislikes. On 4/2/24 at 11:47 AM, the surveyor interviewed the RD in the presence of the Regional RD who stated she spoke to Resident #27 on [redacted] and the resident stated he/she disliked gravy on their food, but she failed to document it. The RD also acknowledged that she should have communicated the dislike to the kitchen. The RD stated the resident attended the Food Committee Meeting on [redacted], and the resident informed her that he/she did not want gravy on their food. A review of the Food Committee Meeting dated 3/21/24, included Resident #27 asked for the facility to not put gravy on all his/her food because it upset their stomach. On 4/3/24 at 11:31 AM, the surveyor interviewed Resident #27 who informed them that last night he/she received meat and noodles on their dinner tray that had gravy on it.	F 806		

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 04/09/2024

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 806	Continued From page 21 On 4/3/2024 at 12:00 PM, the surveyor interviewed the RD who stated she had spoken with the resident this morning who informed her they received gravy on their dinner meal last night. The RD stated she did inform the kitchen yesterday that the resident did not prefer gravy, so their should have been no gravy on the resident's dinner last night. On 4/8/24 at 10:17 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Regional LNHA, Director of Nursing (DON), and survey team acknowledged the facility should honor resident's food preferences. A review of the facility's "Resident Food Preferences Orders" policy dated revised July 2017, included upon the resident's admission the dietician and /or nursing staff will identify a resident's food preferences...	F 806		
F 825 SS=D	NJAC 8:39-17.4(a)1 Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or	F 825		4/12/24

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 04/09/2024

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 825	Continued From page 22 §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident received occupational therapy services in accordance with their therapy plan. This deficient practice was identified for 1 of 2 residents reviewed for rehabilitation (Resident # 131), and was evidenced by the following: On 3/27/24 at 12:29 PM, the surveyor observed the resident in bed with a NJ EX Order. 264b1 lieving device in place. The resident stated that he/she had not received rehabilitation (rehab) therapy since last NJ EX Order. 264b1 when his/her Certified Occupational Therapist Aide (COTA) went out sick. Resident #131 further stated that their COTA came back today, and informed the resident that she thought they had been discharged from therapy since they received no therapy while she was out of the facility. On 4/1/24 at 12:41 PM, the surveyor interviewed Resident #131 who stated he/she had NJ EX Order. 264b1 their stay at the facility for rehab in order to practice transferring from the bed to the NJ EX Order. 264b1, but had not received therapy for the week because his/her therapist was out sick. The resident further stated that the Director of Rehabilitation (DOR) had gone to his/her room on	F 825	1. Resident #131 no longer resides at the facility. 2. All residents have the potential to be affected. Current residents with orders for occupational therapy were reviewed to validate that services were completed. No further variances were noted. 3. The Director of Rehabilitation was re-educated by the Campus Director of Rehabilitation on the policy for completion of therapy evaluations, resident treatment plans and reporting of variances. The Director of Rehabilitation and Campus Director of Rehabilitation re-educated therapy staff on the policy for therapy service, treatment plans and communication of variances. 4. The Corporate Director of Rehabilitation /designee will conduct 3 resident reviews and interviews to validate evaluation completion, therapy treatment plan variances and if noted the reporting of such variances. 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	

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 04/09/2024

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 825	Continued From page 23 [redacted], after the COTA had seen him/her, and the DOR apologized for having left them off the schedule. The resident continued that the DOR assured them that they would receive therapy for the following four days which included [redacted] Resident #131 stated that their COTA came on [redacted] and [redacted] but no one from rehab showed up on [redacted] On 4/2/24 at 11:12 AM, the surveyor interviewed the COTA who confirmed that the facility held a Care Conference for Resident #131 on [redacted], where the resident decided that even though he/she had exhausted their insurance covered therapy days, he/she would continue with rehab services and pay privately. The COTA stated that she had notified the DOR who was responsible for scheduling residents for rehab, and confirmed there should not have been a lapse in Resident #131's therapy. The COTA stated when she returned to the facility from leave, she informed the DOR that Resident #131 had not received therapy. On 4/2/24 at 11:26 AM, the surveyor interviewed the Occupational Therapist (OT) who confirmed Resident #131 had not received therapy from [redacted] to [redacted], and that the DOR was responsible for scheduling residents for rehab. On 4/2/24 at 11:50 AM, the surveyor interviewed the DOR who confirmed that Resident #131 should not have had a lapse in therapy; that he had mistakenly left the resident off the rehab schedule during the time the COTA was out of the facility. The DOR further stated he was not aware of this until the COTA returned and brought it to his attention. The DOR confirmed that he had	F 825	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.	

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 04/09/2024

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 825	Continued From page 24	F 825		

promised the resident he/she would receive therapy for the four days following the return of the COTA. The surveyor asked if he should have followed up to ensure that the resident received their therapy sessions, and the DOR acknowledged that he should have, but that he did not work on weekends. At this time, the surveyor requested from the DOR the rehab notes including the Interdisciplinary Care Plan (IDCP) meeting notes, discharge plans, and policies.

The surveyor reviewed the medical record for Resident #131.

A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included a NJ EX Order. 264b1 .

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, reflected the resident had a brief interview for mental status of NJ EX Order. 264b1; which indicated a NJ EX Or NJ EX Order. 264b1.

On 4/8/24 at 10:52 AM, the surveyor interviewed the Campus Director of Rehab (CDOR) who provided the surveyor with a copy of the Occupational Discharge Summary dated NJ EX Order. 264b which included the discharge plan was to continue therapy with the resident paying privately for services. The CDOR confirmed that the resident should have been scheduled for occupational therapy within twenty-four to forty-eight hours after the discharge.

On 4/8/24 at 11:21 AM, the surveyor reviewed the

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 04/09/2024

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 825	Continued From page 25 Occupational Discharge Summary dated 3/20/24 with the Licensed Nursing Home Administrator (LNHA), who acknowledged the resident should have received therapy during the time period paying privately. No additional documentation was provided. NJAC 8:39-27.1 (a)	F 825		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		4/12/24

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 04/09/2024

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 880	Continued From page 26 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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 04/09/2024

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 880	Continued From page 27 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain infection control standards and procedures during NJ EX Order 2 care treatment. This deficient practice was identified for 1 of 1 NJ EX Order 26 observations observed for 1 of 3 residents reviewed for NJ EX Order. 264b1 and NJ EX Order (Resident #16), and was evidenced by the following: On 3/28/24 at 9:39 AM, the surveyor observed Resident #16 in bed with their eyes closed. The surveyor reviewed the medical record for Resident #16. A review of the Admission Record face sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses that included NJ EX Order. 264b1 A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, reflected the resident had a brief interview for mental status score of NJ EX Order. 264b1; which indicated a NJ EX Order. 264b1 A review of the Physician's Orders included a physician's order (PO) dated NJ EX Order. 26, to cleanse the NJ EX Order. 264b1 with a NJ EX Order. 26 NJ EX Order. 264b1; apply NJ EX Order. 264b1 followed by NJ EX Order. 264b1 (used to aid in NJ EX Order. 264b1 and NJ EX Order. 264b1 and apply a NJ EX Order. 264b1 NJ EX Order. 264b1 daily. On 4/4/24 at 10:25 AM, the surveyor observed the Registered Nurse (RN) perform a NJ EX Order. 2 care treatment on Resident #16, while the Unit	F 880	1. Resident #16 was reviewed with no adverse effect related to the cited event. The identified RN was re-educated on the treatment policy, infection control policy and hand hygiene policy. 2. All residents have the potential to be affected. An observational audit of current residents 5 residents on each unit total of 10 residents was completed by the Director of Nursing/ designee noting handwashing completion, NJ EX Order. 2 cleansing solution use and infection control practices. No variances were noted. 3. The Director of Nursing /designee re-educated licensed nurses on the treatment policy, infection control policy and hand hygiene policy. 4. The Director of Nursing /designee will conduct 3 observational audits of licensed nurses on NJ EX Order. 2 care to validate infection control practices and hand hygiene during the treatment procedure. 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.	

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 04/09/2024

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 880	Continued From page 28	F 880		

Manager/Licensed Practical Nurse (UM/LPN) assisted with the positioning of the resident. The surveyor observed the following:

The RN entered the resident's room and placed a clean barrier onto the resident's overbed table. The RN placed the disposable single-use [NJ EX Order. 2] treatment supplies onto the clean barrier and placed a multi-use bottle of [NJ EX Order. 26] cleansing solution directly onto the overbed table, not on the clean barrier. The RN then washed her hands with soap and water lathering for eleven seconds outside the flow of water. The RN then put on gloves; cleaned the resident's [NJ EX Order. 264] removed her gloves and without performing hand hygiene put on a new pair of gloves. The RN proceeded to apply the NJ EX Order. 264b1; removed her gloves; dated and initialed the [NJ EX Order. 264b2] dressing, and without performing hand hygiene, put on a new pair of gloves and covered the [NJ EX Order. 26] with a [NJ EX Order. 264b2] dressing. After repositioning the resident with the assistance of the UM/LPN, the RN removed her gloves, and performed hand hygiene using soap and water lathering her hands outside the flow of running water for six seconds. The RN put on a new pair of gloves and removed the trash from the resident's room. The RN returned to the resident's room and washed her hands lathering with soap outside the flow of running water for six seconds. The RN then placed the multi-use wound cleansing solution back into the treatment cart without disinfecting it.

On 4/4/24 at 10:53 AM, the surveyor interviewed the RN who confirmed she should have lathered her hands outside the flow of running water for 20-30 seconds; should have performed hand hygiene between glove changes; should not have

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 04/09/2024

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 880	Continued From page 29	F 880		

brought the multi-use [NJ EX Order 2] cleansing solution into the resident's room; and should have discarded the bottle or disinfected it before she placed it back into the treatment cart.

On 4/4/24 at 11:06 AM, the surveyor interviewed the Director of Nursing (DON) who confirmed the facility handwashing policy included washing and lathering hands outside the flow of water for 20-30 seconds, and hand hygiene should be performed between glove changes. The DON also acknowledged any multi-use items brought into the resident's room, should be disinfected before placed back into the treatment cart.

On 4/4/24 at 11:23 AM, the surveyor interviewed the Infection Preventionist/Licensed Practical Nurse (IP/LPN) who confirmed hand hygiene included washing and lathering hands outside the flow of running of water for 20 seconds; hand hygiene should be performed between glove changes; and any multi-use supplies should not be brought into the resident rooms, the amount needed should be poured into a plastic cup or poured onto gauzes.

On 4/4/24 at 12:00 PM, the surveyor interviewed the UM/LPN who had assisted with the positioning of Resident #16 during the [NJ EX Order 2] treatment. The UM/LPN confirmed that she observed the RN did not perform hand hygiene during glove changes, and that the RN should not have brought the [NJ EX Order 2] cleansing solution into the room but rather poured a small amount into a plastic medication cup or onto gauze pads.

On 4/8/24 at 10:18 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the DON, Regional LNHA, and the survey team,

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 04/09/2024

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 880	Continued From page 30	F 880		

confirmed hand hygiene should be performed between glove changes, and that hands should be lathered with soap outside the flow of running water for at least 20 seconds. At this time, the DON stated that all supplies brought into the resident's room should be discarded and that the nurses should only bring in the amount that was needed for that treatment.

A review of the facility's "Handwashing/Hand Hygiene," policy dated revised October 2023, included the facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections...washing hands...wet hands first with warm water, then apply an amount of product recommended by the manufacturer to hands...rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers, rinse hands with water and dry thoroughly with a disposable towel...

A review of the facility's [redacted] Care" policy dated revised October 2010, included the purpose of this procedure is to provide guidelines for the care of [redacted] to promote healing...steps in the procedure...use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table ...take only disposable supplies into the resident's room...place all items to be used during the procedure on the clean field...after the treatment is completed use a clean field saturated with alcohol to wipe the overbed table...wipe reusable supplies with alcohol and return reusable supplies to treatment cart...

NJAC 8:39-19.4(a)

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 04/09/2024

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