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 08/05/2024

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 #: NJ175300 Census: 113 Sample Size: 17 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		9/3/24

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

Electronically Signed | 09/03/2024

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F 842	Continued From page 1	F 842		

records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 2 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint # NJ175300 Based on interviews, medical record review, and review of other pertinent facility documents on 08/05/2024, it was determined that the facility staff failed to consistently document in the "Documentation Survey Report" (DSR) the Activities of Daily Living (ADL) status, follow the Certified Nursing Assistant (CNA) job description and follow its policy titled "Charting and Documentation" for 3 of 3 residents (Resident #2, Resident #12, and Resident #15) reviewed for documentation. This deficient practice was evidenced by the following: 1. According to the "Admission Record" (AR), Resident #2 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1) . The Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Ex Order 26.4(b)(1) revealed that Resident #2 had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated NJ Ex Order 26.4(b)(1) . The MDS also indicated that Resident #2 required NJ Ex Order 26.4(b)(1) to NJ Ex O . Review of Resident #2's Care Plan (CP) revealed a "Focus," initiated on NJ Ex Order 26.4(b)(1) , that Resident	F 842	CORRECTIVE ACTION(S): Resident #2 was reviewed, and there were NJ Ex Order 26.4(b)(1) related to the cited event. The DON/designee has reviewed Resident #2's ADL documentation for the last 7 days, with ADL support provided and documented per the plan of care. Resident #12 was reviewed, and there were NJ Ex Order 26.4(b)(1) related to the cited event. The DON/designee has reviewed Resident #12's ADL documentation for the last 7 days, with ADL support provided and documented per the plan of care. Resident #15 was reviewed, and there were NJ Ex Order 26.4(b)(1) related to the cited event. The DON/designee has reviewed Resident #2's ADL documentation for the last 7 days, with ADL support provided and documented per the plan of care. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE On 9/3/2024 the Director of Nurses/designee reviewed current residents requiring assistance with turning and positioning to validate that documentation was completed. variances were addressed. all residents requiring turning and positioning have potential to be affected	

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F 842	Continued From page 3 #2 had NJ Ex Order 26.4(b)(1) on the NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1). The CP indicated that the resident required "NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) at least every NJ Ex Order 26.4(b)(1), more often as needed or requested." Resident #2's DSR for NJ Ex Order 26.4(b)(1) showed the following: On the 7:00 A.M. to 3:00 P.M. shift, there was no documentation for NJ Ex Order 26.4(b)(1) - NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) for a total of NJ Ex Order 26.4(b)(1) days: On NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1). On the 3:00 P.M. to 11:00 P.M. shift, there was no documentation noted for NJ Ex Order 26.4(b)(1) - NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) for a total of NJ Ex Order 26.4(b)(1) days: On NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). On the 11:00 P.M. to 7:00 A.M. shift, there was no documentation noted for NJ Ex Order 26.4(b)(1) - NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) for a total of NJ Ex Order 26.4(b)(1) days: On NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4(b)(1) Review of Resident #2's Progress Notes (PNs) for NJ Ex Order 26.4(b)(1) revealed no documentation that Resident #2 was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) during the aforementioned shifts. There was no documentation in the PNs for the month of NJ Ex Order 26.4(b)(1)	F 842	MEASURES PUT IN PLACE: The Director of Nursing /designee re-educated the nursing assistants on the facility ADL documentation process, how to access the electronic record and the importance of consistently documenting ADLs per resident plan of care. Education also included the need to notify the DON and/or Administrator of barriers to documentation or accessing the electronic record. MONITORING OF MEASURES: The Director of Nursing /designee will conduct audits of ADL documentation on 3 residents requiring assistance with turning and positioning to validate that care is provided and consistently documented per plan of care. Audits will be completed weekly for four weeks and then monthly for two months. Variances will be addressed. Audit findings will be submitted to the Quality Assurance Performance Improvement Committee monthly x three months for further review and recommendations as needed. Further audit frequency will be determined based on the outcome of the previously completed audit findings.	

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NJ Ex Orde for any worsening in NJ Ex Order 26.4(b)(1)

2. According to the AR, Resident #12 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26. (NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1).

The MDS dated NJ Ex Order 26.4(b)(1) revealed that Resident #12 had a BIMS score of NJ out of 15, which indicated NJ Ex Order 26.4(b)(1).

The MDS also indicated that Resident #12 required NJ Ex Order 26.4(b)(1) to NJ Ex

Review of Resident #12's CP revealed a "Focus," initiated on NJ Ex Order 26.4(b)(1), that Resident #12 had an ADL NJ Ex Order 26.4(b)(1) related to deconditioning after hospitalization and NJ Ex Order 26.4(b with ADLs. The CP indicated that the resident required "1 staff assist with NJ Ex Order 26 and NJ Ex Order 26.4(b)(1)

Resident #12's DSR for NJ Ex Order 26.4(b)(1 showed the following:

On the 7:00 A.M. to 3:00 P.M. shift, there was no documentation for "NJ Ex Order 26.4(b)(1) - NJ Ex Orde and NJ Ex Order 26.4(b)(1) for a total of NJ days: On NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1).

On the 3:00 P.M. to 11:00 P.M. shift, there was no documentation noted for "NJ Ex Order 26.4(b)(1) - NJ Ex Orde and NJ Ex Order 26.4(b)(1) for a total of NJ E days: On NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1),

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F 842	Continued From page 5 NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), and . On the 11:00 P.M. to 7:00 A.M. shift, there was no documentation noted for NJ Ex Order 26.4(b)(1) - NJ Ex Order and NJ Ex Order 26.4(b)(1) for a total of NJ days: On NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and . Review of Resident #12's Progress Notes for NJ Ex Or revealed no documentation that Resident #12 was NJ Ex Order 2 and NJ Ex Order 26.4(b)(1) during the aforementioned shifts. 3. According to the AR, Resident #15 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26. (NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)). The MDS dated revealed that Resident #15 had a BIMS score of NJ E out of 15, which indicated NJ Ex Order 26.4(b)(1) . The MDS also indicated that Resident #15 required NJ Ex Order 26.4(b)(1) to NJ Ex . Review of Resident #15's CP revealed a "Focus," initiated on NJ Ex Order 26.4(b)(1), that Resident #15 had ADL NJ Ex Order 26.4(b)(1) deficit related to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The CP indicated that Resident #15 requires "the NJ Ex Order 26.4(and a NJ Ex Order for NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) Resident #15's DSR for NJ Ex Order 26.4(b)(1 showed the	F 842		

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following:

On the 7:00 A.M. to 3:00 P.M. shift, there was no documentation for "[redacted]" for a total of [redacted] days: On [redacted].

On the 3:00 P.M. to 11:00 P.M. shift, there was no documentation noted for "[redacted]" for a total of [redacted] days: On [redacted].

On the 11:00 A.M. to 7:00 P.M. shift, there was no documentation noted for "[redacted]" for a total of [redacted] days: On [redacted].

Review of Resident #15's PNs for [redacted] revealed no documentation that Resident #15 was [redacted] during the aforementioned shifts.

During an interview on 08/02/2024 at 2:40 P.M., Certified Nursing Assistant (CNA#1) stated that CNAs were responsible for ADL care and that documentation was done in the electronic system. She further stated that [redacted] were provided every [redacted] hours, or more frequently if the resident requested or appeared uncomfortable. CNA #1 stated that blank spaces in DSR may be due to staff forgetting to document the care that was provided, or staff having issues with access to the electronic record.

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F 842	Continued From page 7	F 842		

On 08/05/2024 at 10:49 A.M., the [redacted] stated that it was expected that all documentation was completed by staff by the end of their shift. The [redacted] stated that there should be no missing documentation on the DSR. The [redacted] stated that if residents refused treatment, this should be documented in the progress notes.

On 08/05/2024 at 2:11 P.M., during an interview with the [redacted]) in the presence of the [redacted] stated that CNAs were responsible for completing ADL care and for documenting care provided before the end of their shift. The [redacted] stated "the expectation is that documentation is 100% complete." The [redacted] stated that blank spaces on the ADLs sheet may not mean the task was not completed because the blank could be due to a documentation error.

The [redacted] revealed that the facility changed the format of documentation in [redacted] of [redacted] The [redacted] reported that she has previously recognized that CNAs required additional education related to the format change for documentation. [redacted] reported that auditing of CNA documentation was done routinely, and CNAs were reminded frequently to document care provided to residents.

Review of the facility's job description document for the position "Certified Nurse Assistant/Geriatric Nursing Assistant" revealed under "Duties and Responsibilities": Record all entries on flow sheets, notes, charts, computers etc., in an informative and descriptive manner.

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F 842	Continued From page 8 "Duties and Responsibilities" also include: assist with lifting, turning, moving, positioning, and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc. Review of the facility's policy last revised July 2012, titled "Charting and Documentation", under "Policy Statement" revealed: "All services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." Under "Policy Interpretation and Implementation" #3 the policy stated "Documentation in the medical record will be objective ...complete, and accurate." NJAC 8:39-35.2(f)	F 842		

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	031103	A. BUILDING: _____ B. WING _____	C 08/05/2024

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S 000	Initial Comments Complaint #: NJ165424, NJ173196, NJ175300 Census: 113 Sample: 17 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 # NJ00165424, NJ00173196, NJ00175300 Based on interviews and review of facility documents on 08/05/2024, it was determined that the facility failed to ensure staffing ratios were met for 28 of 28 day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include:	S 560	CORRECTIVE ACTION(S): • Lawrence enter is actively trying to hire CNAs . • "DON, staffing coordinator or designee will review staffing callouts daily and make every effort to replace.	8/31/24

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

Electronically Signed | 09/03/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as 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 of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide 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. 1.For the week of Complaint staffing from 04/14/2024 to 04/27/2024 the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: On 04/14/24 had 8 CNAs for 112 residents on the day shift, required at least 14 CNAs. On 04/15/24 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. On 04/16/24 had 8 CNAs for 111 residents on the day shift, required at least 14 CNAs. On 04/17/24 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs.	S 560	IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE • All residents have the potential to be affected by this practice. MEASURES PUT IN PLACE: Facility's Recruitment and Retention Strategies and Efforts to comply with the State's Staffing Ratios have been in progress, which include but are not limited to the following: 1. Offer bonuses to attract staff. 2. Recruitment bonus to encourage referrals from current staff 3. Facility offers bonuses based on an established bonus plan for any extra shifts being picked up by a CNA. 4. Continue running ads in various social media platforms. 5. Increased Sponsorships of advertisements on social media platforms. 6. Flexible shifts and schedules 7. The facility implemented higher rates for C.N.A. 8. Nursing staff will assist in covering open C.N.A shifts when needed. MONITORING OF MEASURES: • Staffing Coordinator will provide weekly reports to the Director of Nursing and Administrator regarding all efforts made to try to comply with the State’s	

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 08/05/2024

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 On 04/18/24 had 9 CNAs for 111 residents on the day shift, required at least 14 CNAs. On 04/19/24 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. On 04/20/24 had 8 CNAs for 110 residents on the day shift, required at least 14 CNAs. On 04/21/24 had 8 CNAs for 110 residents on the day shift, required at least 14 CNAs. On 04/22/24 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs. On 04/23/24 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. On 04/24/24 had 10 CNAs for 111 residents on the day shift, required at least 14 CNAs. On 04/25/24 had 8 CNAs for 110 residents on the day shift, required at least 14 CNAs. On 04/26/24 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 04/27/24 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. 2. For the 2 weeks of staffing prior to survey from 07/14/2024 to 07/27/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: On 07/14/24 had 11 CNAs for 117 residents on the day shift, required at least 15 CNAs. On 07/15/24 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs.	S 560	Staffing Ratios. • Reports will be submitted to the QAPI Committee monthly X 3 months. • After 3 months QAPI Committee will review if any further changes have to be made.	

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 08/05/2024

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 On 07/16/24 had 10 CNAs for 114 residents on the day shift, required at least 14 CNAs. On 07/17/24 had 11 CNAs for 113 residents on the day shift, required at least 14 CNAs. On 07/18/24 had 10 CNAs for 113 residents on the day shift, required at least 14 CNAs. On 07/19/24 had 11 CNAs for 113 residents on the day shift, required at least 14 CNAs. On 07/20/24 had 9 CNAs for 113 residents on the day shift, required at least 14 CNAs. On 07/21/24 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs. On 07/22/24 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs. On 07/23/24 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs. On 07/24/24 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs. On 07/25/24 had 12 CNAs for 110 residents on the day shift, required at least 14 CNAs. On 07/26/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. On 07/27/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315338 (Y1)	A. Building B. Wing (Y2)	9/10/2024 (Y3)

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 09/03/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
031103		9/10/2024

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 08/30/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
8/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO