	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION 1, 02, 03, 04, 05, 06, 07	(X3) DATE SURVEY COMPLETED		
		315338	B. WING	B. WING			
	ROVIDER OR SUPPLIER	IEADOWS AT LAWRENCE	1	TREET ADDRESS, CITY, STATE, ZIP CODE BISHOPS DRIVE AWRENCEVILLE, NJ 08648	12/21/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETI		
E 000	Initial Comments		E 000				
K 000	Appendix Z-Emergen Provider and Supplier	quirements for Long Term	K 000				
	New Jersey Departm Survey and Field Ope 12/22/21, was found the requirements for Medicare/Medicaid at Safety from Fire, and National Fire Protecti	: 42 CFR 483.90(a), Life the 2012 Edition of the on Association (NFPA) 101, C), Chapter 19 EXISTING					
	built in 90's, It is com construction. The fac	2-story building that was posed of Type II protected ility is divided into 9- smoke does approximately 40 %					
	regulatory flexibilities Emergency for routing maintenance requirer 2020. The flexibilities following items: fire p fire extinguisher moni- operation monthly test testing of generators,	ump weekly/monthly testing, thly inspections, fire fighter sting for elevators, monthly and daily inspection of the reas of construction, repair,					

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	MENT OF HEALTH AN S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				I APPROVI . 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION , 02, 03, 04, 05, 06, 07	(X3) DATE SURVEY COMPLETED	
		315338	B. WING		12/2	21/2021
	ROVIDER OR SUPPLIER	IEADOWS AT LAWRENCE	1 6	REET ADDRESS, CITY, STATE, ZIP CODE BISHOPS DRIVE AWRENCEVILLE, NJ 08648	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
K 000	the survey the census Each cottage is a 1-st composed of Type II of The cottages are divid each. The 3 generato with 100% emergence	ertified beds. At the time of s was 94. tory building. They are unprotected construction. ded into 3-smoke zones rs provide 2 cottages each	K 000			
	This includes: Building 2 - (#2 Mead 02/02/2016 The cottage has 10 co survey the census wa Building 3 - (#4 Mead 02/02/2016	ertified beds. At the time of as 9.				
	The cottage has 10 cd survey the census was Building 4 - (#6 Mead 09/01/2016 The cottage has 10 cd survey the census was Building 5 - (#8 Mead 09/01/2016 The cottage has 10 cd survey the census was Building 6 - (#10 Mead 09/01/2016	ows) Effective date: ertified beds. At the time of as 10. ows) Effective date: ertified beds. At the time of as 10. dows) Effective date:				
K 291 SS=D	survey the census wa Building 7 - (#12 Mea 09/01/2016	dows) Effective date: ertified beds. At the time of	K 291			1/7/22

Event ID: X8H021

Facility ID: NJ31103

If continuation sheet Page 2 of 12

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVI OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 1, 02, 03, 04, 05, 06, 07	(X3) DATE SURVEY COMPLETED
		315338	B. WING		12/21/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
	CE REHAB & HCC/THE N	IEADOWS AT LAWRENCE		BISHOPS DRIVE	
				AWRENCEVILLE, NJ 08648	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTIO
K 291	is provided automatic 18.2.9.1, 19.2.9.1 This REQUIREMENT by: Based on observatio it was determined that a battery backup emergency generator independent of the but and emergency generator	f at least 1-1/2-hour duration cally in accordance with 7.9. is not met as evidenced an and interview on 12/22/21, at the facility failed to provide ergency light above the r's transfer switch, uilding's electrical system trator in accordance with , 19.2.9.1. This deficient	K 291	Corrective action for residents affect the deficient practice. The facility will install battery backup emergency lighting independent of t building's electrical system and emergency generator in accordance NFPA 101:2012 - 7.9 above the switchgear. The emergency lights w	b he e with
	Director, observed in cottage #2 where the transfer switches was not equipped with em independent of the bu and emergency gene This finding was verif Director at the time of	uilding's electrical system rator. ied by the Plant Operations		tested monthly and tested yearly for minutes. The results of the emerger lighting testing will be documented. Identification of other residents havin potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficiency practice. Measures put into place and system	ncy ng the
		Life Safety Code exit 21.		Measures put into place and system changes made to ensure the deficie practice will not recur. The maintenance department will cr log to record both the monthly and y testing of the battery backup emerge lights. The life safety policy will be re to add the testing requirements of th battery backup emergency lights an maintenance staff will be educated of policy.	nt eate a rearly ency evised ne d

Event ID: X8H021

Facility ID: NJ31103

If continuation sheet Page 3 of 12

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES				OMB NO	M APPROV <u> D. 0938-03</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03, 04, 05, 06, 07			E SURVEY PLETED
		315338	B. WING			12	/21/2021
	ROVIDER OR SUPPLIER	MEADOWS AT LAWRENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 1 BISHOPS DRIVE LAWRENCEVILLE, NJ 08648				
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT				(X5) COMPLETIC DATE
K 291	01 Continued From page 3		ĸ	291	The emergency battery backup log will reviewed by the Director of facilities and the results of the emergency backup lighting log will be reported at the quart safety committee meeting.	d	
K 291 SS=D	CFR(s): NFPA 101 Emergency Lighting of Emergency lighting of is provided automation 18.2.9.1, 19.2.9.1	of at least 1-1/2-hour duration cally in accordance with 7.9. Γ is not met as evidenced	ĸ	291	j		1/7/22
	it was determined that a battery backup eme emergency generato independent of the bi- and emergency gene NFPA 101:2012 - 7.9 practice was evidence At 09:18 AM, the Sur Director, observed in cottage #4, where the transfer switches was not equipped with em- independent of the bi- and emergency gene This finding was verif Director at the time of The Plant Operations	uilding's electrical system erator in accordance with y 19.2.9.1. This deficient ed by the following: eveyor and Plant Operations the main electrical room of e emergency generator s located, that the room was hergency lighting uilding's electrical system erator. fied by the Plant Operations of observation. s Director was notified of the Life Safety Code exit			Corrective action for residents affected the deficient practice. The facility will install battery backup emergency lighting independent of the building's electrical system and emergency generator in accordance wi NFPA 101:2012 - 7.9 above the switchgear. The emergency lights will b tested monthly and tested yearly for 90 minutes. The results of the emergency lighting testing will be documented. Identification of other residents having f potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficiency practice. Measures put into place and systemic changes made to ensure the deficient practice will not recur. The maintenance department will creat	the	

Facility ID: NJ31103

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	O. 0938-03
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG 0 1	1, 02, 03, 04, 05, 06, 07	COMPLETED	
		315338	B. WING			12	2/21/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	REET ADDRESS, CITY, STATE, ZIP CODE		
LAWRENG	CE REHAB & HCC/THE N	MEADOWS AT LAWRENCE			BISHOPS DRIVE AWRENCEVILLE, NJ 08648		
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO T			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
K 291	Continued From page	e 4	ĸ	291			
K 291 SS=D	NJAC 8:39-31.2(e) NFPA 101:2012 - 19. Emergency Lighting CFR(s): NFPA 101	2.9.1, 7.9	ĸ	291	log to record both the monthly and year testing of the battery backup emergence lights. The life safety policy will be revise to add the testing requirements of the battery backup emergency lights and maintenance staff will be educated on the policy. How Corrective actions will be monitored The emergency battery backup log will reviewed by the Director of facilities and the results of the emergency backup lighting log will be reported at the quart safety committee meeting.	y sed the ed. I be d	1/7/22
	is provided automatic 18.2.9.1, 19.2.9.1 This REQUIREMENT by: Based on observatio it was determined that a battery backup eme emergency generator independent of the but and emergency generator independent of the but and emergency generator NFPA 101:2012 - 7.9 practice was evidenc At 09:29 AM, the Sur Director, observed in cottage #6, where the transfer switches was not equipped with em	uilding's electrical system erator in accordance with , 19.2.9.1. This deficient ed by the following: veyor and Plant Operations the main electrical room of e emergency generator s located, that the room was			Corrective action for residents affected the deficient practice. The facility will install battery backup emergency lighting independent of the building's electrical system and emergency generator in accordance wi NFPA 101:2012 - 7.9 above the switchgear. The emergency lights will b tested monthly and tested yearly for 90 minutes. The results of the emergency lighting testing will be documented. Identification of other residents having a potential to be affected by the same	th	

Facility ID: NJ31103

If continuation sheet Page 5 of 12

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 03/18/2024 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03, 04, 05, 06, 07			E SURVEY PLETED
		315338	B. WING _			12/21/2021	
	ROVIDER OR SUPPLIER	IEADOWS AT LAWRENCE		1	REET ADDRESS, CITY, STATE, ZIP CODE BISHOPS DRIVE AWRENCEVILLE, NJ 08648		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 291	Covid-19 case pendir Plant Operations Dire above. The Plant Operations	rator. observed due to possible ng. The interview with the ector confirmed the finding Director was notified of the Life Safety Code exit 21.	K 2	291	 deficient practice. All residents have the potential to be affected by the deficiency practice. Measures put into place and systemic changes made to ensure the deficient practice will not recur. The maintenance department will creat log to record both the monthly and year testing of the battery backup emergence lights. The life safety policy will be revise to add the testing requirements of the battery backup emergency lights and maintenance staff will be educated on the policy. How Corrective actions will be monitore. The emergency battery backup log will reviewed by the Director of facilities an the results of the emergency backup lighting log will be reported at the quart 	rly sed the ed. I be d	
K 291 SS=D	Emergency Lighting Emergency lighting o is provided automatic 18.2.9.1, 19.2.9.1 This REQUIREMENT	f at least 1-1/2-hour duration ally in accordance with 7.9. - is not met as evidenced	K 2	291	safety committee meeting.		1/7/22
	it was determined that a battery backup eme emergency generator independent of the bu	n and interview on 12/22/21, at the facility failed to provide ergency light above the r's transfer switch, uilding's electrical system rator in accordance with			Corrective action for residents affected the deficient practice. The facility will install battery backup emergency lighting independent of the building's electrical system and	i by	

Facility ID: NJ31103

If continuation sheet Page 6 of 12

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/18/20 FORM APPROVE OMB NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION G 01, 02, 03, 04, 05, 06, 07	(X3) DATE SURVEY COMPLETED
		315338	B. WING		12/21/2021
	ROVIDER OR SUPPLIER	I IEADOWS AT LAWRENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 1 BISHOPS DRIVE LAWRENCEVILLE, NJ 08648	12/2//2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
K 291	practice was evidence At 09:35 AM, the Sur Director, observed in cottage #8, where the transfer switches was not equipped with em independent of the bu and emergency gene This finding was verif Director at the time of The Plant Operations	, 19.2.9.1. This deficient ed by the following: veyor and Plant Operations the main electrical room of e emergency generator s located, that the room was hergency lighting uilding's electrical system rator. ied by the Plant Operations f observation. Director was notified of the Life Safety Code exit 21.	K 25	 emergency generator in accordance NFPA 101:2012 - 7.9 above the switchgear. The emergency lights at tested monthly and tested yearly for minutes. The results of the emerge lighting testing will be documented. Identification of other residents hav potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficiency practice. Measures put into place and system changes made to ensure the deficien practice will not recur. The maintenance department will consider the battery backup emergency lights at maintenance staff will be educated policy. How Corrective actions will be more the results of the emergency battery backup log reviewed by the Director of facilities the results of the emergency backup lighting log will be reported at the quarter staff will be reported at the quarter staff version. 	will be or 90 ency ving the e be mic ent create a yearly gency revised the nd on the nitored. g will be s and up
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101		K 29		1/7/22
		f at least 1-1/2-hour duration ally in accordance with 7.9.			

Facility ID: NJ31103

If continuation sheet Page 7 of 12

	-	ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 03/18/2024 DRM APPROVED NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03, 04, 05, 06, 07			ATE SURVEY OMPLETED
		315338	B. WING			12/21/2021	
	ROVIDER OR SUPPLIER	IEADOWS AT LAWRENCE	-	1	TREET ADDRESS, CITY, STATE, ZIP CODE BISHOPS DRIVE AWRENCEVILLE, NJ 08648	•	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 291	18.2.9.1, 19.2.9.1 This REQUIREMENT by: Based on observatio it was determined that a battery backup eme emergency generator independent of the bu and emergency gene NFPA 101:2012 - 7.9, practice was evidence At 09:48 AM, the Sum Director, observed in cottage #10, where the transfer switches was not equipped with em- independent of the bu and emergency gene This finding was verifind Director at the time of The Plant Operations	 is not met as evidenced n and interview on 12/22/21, it the facility failed to provide ergency light above the 's transfer switch, uilding's electrical system rator in accordance with , 19.2.9.1. This deficient ed by the following: veyor and Plant Operations the main electrical room of ne emergency generator is located, that the room was bergency lighting uilding's electrical system rator. ied by the Plant Operations f observation. Director was notified of the Life Safety Code exit 21. 	К	291	Corrective action for residents affected the deficient practice. The facility will install battery backup emergency lighting independent of the building's electrical system and emergency generator in accordance of NFPA 101:2012 - 7.9 above the switchgear. The emergency lights will tested monthly and tested yearly for S minutes. The results of the emergency lighting testing will be documented. Identification of other residents having potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficiency practice. Measures put into place and systemic changes made to ensure the deficien practice will not recur. The maintenance department will cree log to record both the monthly and yes testing of the battery backup emergency lights. The life safety policy will be revite to add the testing requirements of the battery backup emergency lights and maintenance staff will be educated or policy. How Corrective actions will be monitor The emergency battery backup log w reviewed by the Director of facilities a the results of the emergency backup	e with I be 20 cy g the c t ate a arly vised e arthe cy vised ored. vill be	

Event ID: X8H021

Facility ID: NJ31103

If continuation sheet Page 8 of 12

TATEMENT (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION 1, 02, 03, 04, 05, 06, 07	(X3) DATE SURVEY COMPLETED	
		315338	B. WING			12	/21/2021
	ROVIDER OR SUPPLIER	IEADOWS AT LAWRENCE		1	TREET ADDRESS, CITY, STATE, ZIP CODE BISHOPS DRIVE AWRENCEVILLE, NJ 08648	<u>, , , , , , , , , , , , , , , , , , , </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
K 291 K 291 SS=D		e 8		291 291	lighting log will be reported at the quart safety committee meeting.	erly	1/7/22
	is provided automatic 18.2.9.1, 19.2.9.1 This REQUIREMENT by: Based on observatio it was determined that a battery backup eme emergency generator independent of the bu and emergency gene NFPA 101:2012 - 7.9 practice was evidence At 10:10 AM, the Sur Director, observed in cottage #12, where the transfer switches was not equipped with em- independent of the bu and emergency gene This finding was veriff Director at the time of The Plant Operations	uilding's electrical system rator in accordance with , 19.2.9.1. This deficient ed by the following: veyor and Plant Operations the main electrical room of ne emergency generator is located, that the room was nergency lighting uilding's electrical system rator. ied by the Plant Operations f observation. Director was notified of the Life Safety Code exit 21.			Corrective action for residents affected the deficient practice. The facility will install battery backup emergency lighting independent of the building's electrical system and emergency generator in accordance wi NFPA 101:2012 - 7.9 above the switchgear. The emergency lights will b tested monthly and tested yearly for 90 minutes. The results of the emergency lighting testing will be documented. Identification of other residents having potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficiency practice. Measures put into place and systemic changes made to ensure the deficient practice will not recur. The maintenance department will creat log to record both the monthly and year testing of the battery backup emergence lights. The life safety policy will be revise	the the rly	

Event ID: X8H021

Facility ID: NJ31103

If continuation sheet Page 9 of 12

CENTER		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVE D. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION I, 02, 03, 04, 05, 06, 07	(X3) DATE SURVEY COMPLETED		
		315338	B. WING _			12	/21/2021	
	ROVIDER OR SUPPLIER	IEADOWS AT LAWRENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 1 BISHOPS DRIVE					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		AWRENCEVILLE, NJ 08648 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
K 291	Continued From page	e 9	K 2	91	to add the testing requirements of the battery backup emergency lights and maintenance staff will be educated on policy. How Corrective actions will be monitor The emergency battery backup log wi reviewed by the Director of facilities an the results of the emergency backup lighting log will be reported at the quar safety committee meeting.	ed. II be id		
K 918 SS=E	CFR(s): NFPA 101 Electrical Systems - E Maintenance and Tes The generator or oth and associated equip service within 10 sec criterion is not met du process shall be prov capability for the life s Maintenance and tes transfer switches are with NFPA 110. Generator sets are in under load 30 minute day intervals, and exe months for 4 continue under load conditions simulated cold start at transfer of all EES loa competent personnel stored energy power accordance with NFP	er alternate power source oment is capable of supplying onds. If the 10-second uring the monthly test, a rided to annually confirm this safety and critical branches. ting of the generator and performed in accordance spected weekly, exercised as 12 times a year in 20-40 ercised once every 36 bus hours. Scheduled test include a complete and automatic or manual ads, and are conducted by . Maintenance and testing of sources (Type 3 EES) are in PA 111. Main and feeder aspected annually, and a ally exercising the	K9	118			1/7/22	

Facility ID: NJ31103

If continuation sheet Page 10 of 12

		ND HUMAN SERVICES			PRINTED: 03/18 FORM APPR OMB NO. 0938	OVE
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION 01, 02, 03, 04, 05, 06, 07	(X3) DATE SURVEY COMPLETED	
		315338	B. WING		12/21/202	1
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
				1 BISHOPS DRIVE		
LAWRENG	SE REHAB & HCC/THE N	MEADOWS AT LAWRENCE		LAWRENCEVILLE, NJ 08648		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPL	ETION
K 918	Continued From page	e 10	K 91	3		
		ments. Written records of				
		ting are maintained and S electrical panels and				
		•				
		eadily identifiable, and I power circuits. Minimizing				
	-	age of the emergency power				
	source is a design co					
	installations.					
		, 6.6.4 (NFPA 99), NFPA 110, NFPA				
		11, 700.10 (NFPA 70)				
	This REQUIREMENT is not met as evidenced					
	by:					
	Based on interview a	and review of facility		Corrective action for residents affe	cted by	
		21, in the presence of the		the deficient practice.		
		r and Plant Operations				
		mined that the facility failed		The Plant Services dept. will obser	ve the	
		eded by their generator to		time delay from normal power to		
	-	building was within the		emergency power during the month	nly load	
	-	ime frame, in accordance		test and record it on the generator		
	-	ergency electrical generator		sheet.	5	
	systems.	<i>c</i> , <i>c</i>				
	-			Identification of other residents hav	ing the	
	This deficient practice	e was evidenced by the		potential to be affected by the same	•	
	following:			deficient practice.		
	A review of the gener	rator records for the previous		All residents have the potential to b	e	
		ot reveal documented		affected by the deficiency practice.		
	certification that the g	generator would start and				
	transfer power to the	building within ten seconds,		Measures put into place and syster		
	when the load test wa			changes made to ensure the deficient	ent	
		6/21, 10/22/21, 09/04/21,		practice will not recur.		
		io June date, 05/28/21,		The generator testing policy will be		
)2/26/21, 01/22/21 and		revised to reflect the recording of the		
	12/25/21.			delay from normal power to emerge		
				power. The generator log will be re		
		ducted with the Maintenance		to add the time delay on the log she	eet.	
		f the record review, who				
		no transfer time data on 12		How Corrective actions will be mon		
	ot 12 monthly load te	sts documented on his		The Generator log sheet will be re-	viewed	

Facility ID: NJ31103

If continuation sheet Page 11 of 12

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA				
	IDENTIFICATION NUMBER:	· /	E CONSTRUCTION 01, 02, 03, 04, 05, 06, 07	(X3) DATE SURVEY COMPLETED	
	315338	B. WING		12	2/21/2021
OVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
E REHAB & HCC/THE N	MEADOWS AT LAWRENCE				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
Continued From page	e 11	K 918	3		
report's.					
was informed of the o	deficiency at the Life Safety				
NJAC 8:39-31.2(e), 3 NFPA 99	31.2(g)				
	E REHAB & HCC/THE I SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page report's. The Plant Operations was informed of the o Code exit conference NJAC 8:39-31.2(e), 3	Continued From page 11 report's. The Plant Operations Director and Administrator was informed of the deficiency at the Life Safety Code exit conference on 12/22/21.	DVIDER OR SUPPLIER ID E REHAB & HCC/THE MEADOWS AT LAWRENCE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 11 K 918 report's. K 918 The Plant Operations Director and Administrator was informed of the deficiency at the Life Safety Code exit conference on 12/22/21. NJAC 8:39-31.2(e), 31.2(g)	DVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE E REHAB & HCC/THE MEADOWS AT LAWRENCE 1 BISHOPS DRIVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) Continued From page 11 K 918 VH Director of facilities and the of the monthly load tests will be re at the quarterly safety committee The Plant Operations Director and Administrator was informed of the deficiency at the Life Safety Code exit conference on 12/22/21. K 918	DVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE E REHAB & HCC/THE MEADOWS AT LAWRENCE 1 BISHOPS DRIVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 11 report's. K 918 by the Director of facilities and the results of the monthly load tests will be reported at the quarterly safety committee meeting. NJAC 8:39-31.2(e), 31.2(g) NJAC 8:39-31.2(e), 31.2(g) STREET ADDRESS, CITY, STATE, ZIP CODE

Event ID: X8H021

Facility ID: NJ31103

If continuation sheet Page 12 of 12

POST-CERTIFICATION REVISIT REPORT

			DATE OF REVISIT	
	A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	3/30/2022	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAWRENCE REHAB & HCC/THE I	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).

ITE	м	DATE	ITEM		DATE	ITEM		DATE
Y4	ļ	Y5	Y4		Y5	Y4		Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0918	01/07/2022			_			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC								
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC								
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC								
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC						LSC		
REVIEWE STATE AC		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF	SURVEYOR	1	DATE	
REVIEWE CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 12/21/2021					S. WAS A SUMMARY OF IT TO THE FACILITY?			
Form CMS	S - 2567B (09/92)	EF (11/06)		Page 1 of 1		EVENT II	D: X8H022	

POST-CERTIFICATION REVISIT REPORT

	A. Building 03 - COTTAGE 2 AT 4 MORRIS HALL CIRCLE			DATE OF REVISIT	
				3/30/2022	
315556 Y1	D. Wing		Y2	5/50/2022	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
LAWRENCE REHAB & HCC/THE I	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).

ITE	Μ	DATE	ITEM	I	DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix		Correction	ID Prefix	Co	orrection	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	Co	ompleted	Reg. #		Completed
LSC	K0291	01/07/2022				LSC		
ID Prefix		Correction	ID Prefix	Co	orrection	ID Prefix		Correction
Reg. #		Completed	Reg. #	Co	ompleted	Reg. #		Completed
LSC						LSC		
ID Prefix		Correction	ID Prefix	Co	orrection	ID Prefix		Correction
Reg. #		Completed	Reg. #	Co	ompleted	Reg. #		Completed
LSC						LSC		
ID Prefix		Correction	ID Prefix	Co	orrection	ID Prefix		Correction
Reg. #		Completed	Reg. #	Co	ompleted	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix	Co	orrection	ID Prefix		Correction
Reg. #		Completed	Reg. #	Co	ompleted	Reg. #		Completed
LSC			LSC			LSC		
REVIEWE STATE AG		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVE	EYOR		DATE	
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 12/21/2021			R ANY UNCORRECTED DI CTED DEFICIENCIES (CM					

POST-CERTIFICATION REVISIT REPORT

				DATE OF REVISIT	
	A. Building 04 - COTTAGE 3 AT 6 MORRIS H B. Wing	3/30/2022	Y3		
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
LAWRENCE REHAB & HCC/THE I	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).

ITE	м	DATE	ITEM		DATE	ITEM		DATE
Y4	ļ	Y5	Y4		Y5	Y4		Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0291	01/07/2022			_			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC						LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC								
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC								
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC					_	LSC		
REVIEWE STATE AC		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF	SURVEYOR		DATE	
REVIEWE CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 12/21/2021					S. WAS A SUMMARY OF T TO THE FACILITY?	YES		
Form CMS - 2567B (09/92) EF (11/06)			Page 1 of 1		EVENT I	D: X8H022		