STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315113	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	112 FRANKLIN CORNER ROAD , LAWRENCEVILLE, New Jersey, 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
F0000	INITIAL COMMENTS A Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health. Complaint #: 389201, 389203, 389204, 2561742, 2648198, and 2669876 Survey Dates: 02/16/26 – 02/19/26 Survey Census: 98 Sample Size: 6 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F0000		03/05/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061104	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	**112 FRANKLIN CORNER ROAD , LAWRENCEVILLE, New Jersey, 08648**

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S0000	Initial Comments Complaint #: 389201, 389203, 389204, 2561742, 2648198, and 2669876 Survey Dates: 02/16/26 – 02/19/26 Survey Census: 98 Sample Size: 6 The facility was not in compliance with the standards in the New Jersey Administrative code, Chapter 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S0000		03/05/2026
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint #: 389201, 389204, 389206, 2561742, 2648198, 2669876 Based on interviews and review of facility documents on 2/19/2026, it was determined that the facility failed to ensure staffing ratios were met for 4 of 63-day shifts. This deficient practice had the potential to affect all residents. 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	S0560	How will the corrective action be accomplished for those residents found to be affected by this practice? The staffing coordinator was re-educated on the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. The facility will continue to reach out to existing staff and contracted agency staff to see if they can pick up extra and overtime shifts to continue to try and staff accordingly. How will the Facility identify other residents having the potential to be affected by the same deficient practice? All residents have the ability to be affected by the facility failing to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. What measures will be put in place or what systemic	03/05/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061104	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	112 FRANKLIN CORNER ROAD , LAWRENCEVILLE, New Jersey, 08648

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S0560	Continued from page 1 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. For the 2 weeks of Complaint staffing from 2/16/2025-3/1/2025, the facility was deficient in CNA staffing for residents on 2 of 14 day shits as follows: On 2/17/25, the facility had 11 CNAs for 94 residents on the day shift, required at least 12 On 2/18/25, the facility had 11 CNAs for 96 residents on the days shift, required at least 12 For the 2 weeks of Complaint staffing from 6/29/25-7/12/25, the facility was deficient in CNA staffing for residents 2 of 14 day shifts as follows: On 7/5/25, the facility had 11 CNAs for 94 residents on the day shift, required at least 12. On 7/12/25 the facility had 10 CNAs for 93 residents on the day shift, required at least 11.	S0560	Continued from page 1 changes will be made to ensure that the deficient practice will not recur? The facility will continue to post job openings on job sites to promote CNA applications and hirings. The facility has contracted with multiple staffing agencies to assist with our staffing needs. The administrator/ designee will review the daily staffing sheets weekly x 4 then monthly for 3 months and quarterly thereafter. How will the Facility monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place)? The Administrator will review any findings of these audits and present them quarterly with the QAPI committee to determine frequency of future audits.	03/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315113	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	112 FRANKLIN CORNER ROAD , LAWRENCEVILLE, New Jersey, 08648

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 03/09/2026 in relation to the survey 02/19/2026 complaint survey. The facility was found to be in compliance with 42CFR Part 483, requirements for the Long Term Care Facilities.	F0000		03/09/2026

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 reverse for further 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.

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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061104	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 03/09/2026 in relation to the 02/19/2026 State of New Jersey Complaint survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities.	S0000		03/09/2026

Office of Primary Care and Health Systems Management

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