STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 #: NJ169579, 170062, 170190, 171246, 171258 Survey Date: 09/03/24 - 09/06/24 Census: 48 Sample: 12 + 3 closed record 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 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 record review and review of other pertinent facility documentation, it was determined that the facility failed to ensure that the administration of a resident's [NJ Ex Order 26.4(b)(1)] [redacted]) was consistently documented to indicate if it were administered or held on the Medication Administration Record. This deficient practice was identified for 1 of 1 resident, (Resident #27) reviewed for [NJ Ex Ord] [redacted]. This deficient practice was evidenced by the following:	F 658	1. Resident #27 was evaluated by licensed nurse and registered dietitian and [NJ Ex Order 26.4b1] were identified related to cited event. Resident #27□s documentation was reviewed by the Director of Nursing as of 9/18/2024 to validate consistent documentation of [NJ Ex Order 26.4b1] with no further concerns identified. 2. Current residents receiving enteral nutrition have the potential to be affected by this deficient practice. An audit was completed of current residents receiving	9/30/24

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

Electronically Signed | 09/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 1 During the initial tour of the facility on 09/03/24 at 8:38 AM, the surveyor observed Resident #27 lying awake in bed. The resident stated that their NJ Ex Order 26.4(b)(1) four to five weeks ago. A review of Resident #27's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included but was not limited to: other NJ Ex Order 26.4(b)(1) [redacted], and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) [redacted] A review of Resident #27's Admission Minimum Data Set (MDS), an assessment tool, revealed that the resident had Brief Interview for Mental Status Score (BIMS) of [redacted] out of 15, which indicated that the resident was NJ Ex Order 26.4(b)(1) [redacted] Further review of the MDS indicated that the resident had a NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) during meals or when NJ Ex Order 26.4(b)(1) and complaints of NJ Ex Order 26.4(b)(1) . The MDS specified that the resident experienced [redacted] and had a NJ Ex Order 26.4(b)(1) [redacted]). A review of Resident #27's Care Plan revealed an entry dated [redacted], that had a Focus of: "I have a [redacted] problem or potential [redacted] problem, risk for [redacted] r/t (related to) NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) [redacted] add [redacted]	F 658	enteral nutrition on 9/18/2024 by DON to validate consistent documentation of administration, refusal, or hold. Variances were addressed. 3. The DON/designee re-educated Licensed Nurses on providing services that meet professional standards including but not limited to documenting administration, hold, or refusal of enteral feedings. 4. The DON/designee will complete an audit of 3 residents on enteral feedings to validate for consistent documentation of administration, hold, or refusal. These audits will be completed weekly x 4 weeks and monthly x 2 months. The findings of the audits will be submitted by the Director of Nursing to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 2	F 658		

NJ Ex Order 26.4(b)(1) . Goals included but were not limited to: I will tolerate NJ Ex Order 26.4(b) 100% by next review date, ...I will be free from s/sx (signs and symptoms) of NJ Ex Order 26.4(b)(1) through next review date...My NJ Ex Order 26.4(b)(1) will be improved or maintained by next review date and My NJ Ex Order 26.4(b)(1) will show improvement by next review date. Interventions included but were not limited to: Provide and NJ Ex Order 26.4(b)(1) as ordered: NJ Exec Order 26.4b1 :NJ Ex Order 26.4(b)(1) ..via NJ Ex O to meet NJ Ex Order 26.4(b)(1) , monitor and record NJ Ex Order 26.4(b)(1) ...

A review of Resident #27's Order Summary Report revealed an order dated NJ Ex Order 26.4(b) for NJ Ex Orde A second order dated NJ Ex Order 26.4(b) , for NJ Ex Order 26. in the afternoon NJ Ex Order 26.4(b)(1)

A review of Resident #27's NJ Ex Order 26.4(b)(1) Medication Administration Record (MAR) revealed an entry for an NJ Ex Order 26.4(b)(1) in the afternoon NJ Ex Order 26.4(b)(1) every shift, NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1) medication start date NJ Ex Order 26.4(b) . Further review of the entry revealed that on NJ Ex Order 26.4(b) , NJ Ex Order 26.4(b) , NJ Ex Order 26.4(b) , and NJ Ex Order 26.4(b) at 1400 (2:00 PM) the order was not signed out to indicate whether the NJ Ex Order 26.4(b)(1) was admininistered or held and the fields that were allotted for charting were left blank.

A review of Resident #27's Progress Notes within

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD 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 3	F 658		

the electronic health record (EHR) from NJ Ex Order 26.4(b) through NJ Ex Order 26.4(b)(, did not indicate that the resident left the facility or experienced difficulties with NJ Ex Order 26.4(b)(1) administration.

On 09/05/23 at 10:09 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that the resident went out to the hospital on NJ Ex Order 26.4(b, and the entry for NJ Ex Order 26.4(b)(1) administration on the MAR was left blank but there was documentation on the MAR on NJ Ex Order 26.4(b) , that the entry was signed out as held on that date. The U.S. FOIA (b) (6) stated that the entry should have been charted as not administered if the resident were not here. The U.S. FOIA (b) (6) reviewed the NJ Exec Order 2 MAR and stated that on NJ Ex Order 26.4(b)(, NJ Ex Order 26.4(b , and NJ Ex Order 26.4(b) , the patient was in the building and the nurse did not properly document. The U.S. FOIA (b) (6) stated there was no excuse why she was not documenting. The U.S. FOIA (b) (6) further stated that even on NJ Ex Order 26.4(b , NJ Ex Order 26.4(b , NJ Ex Order 26.4(b)(, and NJ Ex Order 26.4(b blanks were noted on the MAR. The U.S. FOIA (b) (6) stated that she did not know why it was not signed out, but "the patient was in the building and I think it was missed". The U.S. FOIA (b) (6) stated that there were no orders in place to indicate that the NJ Ex Order 26.4(b)(1) was held for any reason.

On 09/05/24 at 11:44 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that she would not expect to see blanks on the MAR. The U.S. FOIA (stated that a lack of documentation was a problem. The U.S. FOIA (stated that sometimes care was given and provided, but they just did not sign. The U.S. FOIA (further stated, "In nursing, if you did not document, you did not do it."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 4 A review of the facility policy, "Enteral Tube Feeding via Continuous Pump" (Revised November 2018) revealed the following: ...Documentation: The person performing this procedure should record the following information in the resident's medical record: 1. The date and time the procedure was performed. ...9. The signature and title of the person recording the data. A review of an undated facility policy, "Administering Medications" revealed the following: ...The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.	F 658		
F 812 SS=E	NJAC 8:39-29.2(d), 27.1(a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		9/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 812	Continued From page 5 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. 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 handle potentially hazardous food to prevent food borne illness. This deficient practice was evidenced by the following: On 09/03/24 at 8:46 AM, during the initial tour of the kitchen, the surveyor observed the following in the walk-in meat freezer in the presence of two (2) Food Service Directors (FSD #1 and FSD #2). 1. An opened slab of roast beef on the top shelf was not labeled or dated. 2. An opened bag containing six (6) salisbury patties was not labeled or dated. At that time, during an interview with the surveyor, FSD #1 stated, "everything that is in the freezer should have dates. Once it is opened, it should be dated." FSD #2 discarded the roast beef and salisbury patties. On 09/05/24 at 1:15 PM, during an interview with the surveyor, the U.S. FOIA (b) (6) [redacted] stated, "when food packages are opened, it should be labeled and dated with the use by date."	F 812	1. No specific resident(s) were identified by the cited event. The open slab of roast beef and 6 Salisbury patties identified were discarded by the Food Service Director on 09/03/24. 2. Current residents who eat facility-provided meals have the potential to be affected by the cited event. The Food Service Director completed an audit of the food items in the walk-in meat freezer on 9/04/2024, 9/05/2024, and 9/06/2024 to validate that opened food packages were labeled and dated. No other variances were noted. 3.The Regional Director of Food Service re-educated the facility's U.S. FOIA (b) (6) [redacted] on the facility's Food Storage policy, including but not limited to the need for opened food items to be labeled and dated consistently. The facility's Food Service Director re-educated dietary staff regarding the facility's Food Storage policy, including but not limited to the need for opened food items to be labeled and dated consistently. 4. The FSD/designee will conduct 3 rounds weekly to validate that opened food items in the walk-in meat freezer are consistently labeled and dated. Variances will be immediately addressed. These audits will be completed weekly x 4 weeks	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 812	Continued From page 6 A review of the facility policy titled Food Receiving and Storage (revised November 2022) revealed, "Refrigerated/Frozen Storage 1. All foods stored in the refrigerator or freezer are covered, labeled and dated ("use by" date). NJAC 8:39-17.2 (g)	F 812	and then monthly x 2 months. The findings of the audits will be submitted by the Food Service Director to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained	
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon	F 865		9/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 865	Continued From page 7	F 865		

request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 865	Continued From page 8 defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to ensure that their Quality Assurance and Performance Improvement	F 865	1. No specific residents were identified by the cited event. 2. Current residents have the potential to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 865	Continued From page 9 Program's (QAPI) sources of quantitative data was being analyzed to evaluate program effectiveness and implement new processes. This deficient practice was identified during the standard survey and was evidenced by the following: Refer to S1410 On 09/03/24 at 08:32 AM, during the entrance conference the surveyor requested the facility's QAPI book. On 09/06/24 at 08:45 AM, the U.S. FOIA (b) (6) [redacted]) provided the QAPI book. A review of the QAPI book revealed that the facility started a QAPI in NJ Exec Order 26.4b1 on the NJ Ex Order 26.4(b)(1) [redacted]) for employee health and that the U.S. FOIA (b) (6) [redacted] and US FOIA (b)(6) [redacted] were responsible to audit the active employee files which was ongoing. Further review of the QAPI book revealed that in NJ Exec Order 26.4b1 [redacted] the NJ Ex Order 26.4(b)(1) QAPI was still ongoing. On 09/06/24 at 09:37 AM, the U.S. FOIA (b) [redacted] provided an audit that was completed only for the newly hired employees for NJ Exec Order 26.4b1. There was no documented evidence that an audit was completed for active employees from NJ Exec Order 26 [redacted]	F 865	be affected by the cited event. Active facility QAPI plans to include but not limited to employee health 2-step TB process were reviewed to validate that an audit process was in place, completed and data analysis was reviewed at the ad hoc QAPI meeting held on 9/23/2024. 3. The campus Executive Vice President (EVP) will re-educate the facility U.S. FOIA (b) (6) and facility IDT members on the QAPI program and process. The re-education included the need to analyze quantitative data to evaluate program effectiveness and the possible need for further intervention or new processes. 4. The EVP/designee will conduct an audit of QAPI Meeting minutes to include audits to validate that the QAPI process includes analysis of quantitative data to evaluate program effectiveness and the possible need for further intervention or new processes. These audits will be completed monthly x 3 months. The findings of the audits will be submitted by the EVP to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 865	Continued From page 10 During an interview with the surveyor on 09/06/24 at 09:52 AM, the U.S. FOIA (b) stated, in the presence of the survey team, that QAPI was the process to monitor the improvement of the identified concerns. She further stated that if there was no improvement, then the QAPI committee reviewed why it was not improving and what interventions could be put into place. When asked about the provided audit, the U.S. FOIA (b) stated that the January audit that was provided for the employee health NJ Ex Order 26.4(b)(1) was completed for the newly hired employees and not the active employees. She further stated that the expectation would be to audit all of the active employees as indicated by the QAPI plan. The U.S. FOIA (b) confirmed that the audits from February to NJ Exec Order 26.4b1 were not completed. The U.S. FOIA (b) acknowledged that since there was a QAPI on it, there should have been audits completed from NJ Exec Order 26.4b1 on the active employees and the information should have been presented at the QAPI meetings. During an interview with the surveyor on 09/06/24 at 10:22 AM, the U.S. FOIA (b) (6)) stated in the presence of the survey team, that she started the QAPI on employee health NJ Ex Order 26.4(b)(1) for active employees because she was trying to put a system in place to have the files in order. The U.S. further stated that she started with the newly hired employees in January because it would be "easier." When asked about the ongoing audits, the U.S. stated it "fell by the way side." The U.S. emphasized the plan was to review all the active employees, but they started with the newly hired employees first. The U.S. confirmed there were no other audits completed for the active employees related to the employee health NJ Ex Order 26.4(b)(1). She	F 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 865	Continued From page 11 further stated that the expectation was that all active employees should have been reviewed since it was brought to QAPI. A review of the facility's undated Quality Assurance and Performance Improvement (QAPI) Program policy, included, "2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include a. tracking and measuring performance. 3. The committee meets at least quarterly (or more often as necessary) to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan. NJAC 8:39-33.1(a)(e); 33.2 (a)(b)(c)(d)	F 865		
F 880 SS=F	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	F 880		9/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 12	F 880		

arrangement based upon the facility assessment conducted according to §483.71 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:
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 13 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: Based on interview and review of other pertinent facility documentation, it was determined that the facility who had been in an active NJ Ex Order 26.4(b)(1) [redacted] since NJ Ex Order 26.4(b) [redacted], failed to conduct complete and thorough NJ Ex Order 26.4(b)(1) [redacted] upon the identification of a single new case of NJ Ex Order 26.4(b)(1) [redacted] in a resident or staff member in accordance with the facility policy, Centers for Disease Control (CDC), Local Health Department, State Health Department and all current guidance related to infection control. This deficient practice was identified for 1 of 1 resident, (Resident #21) reviewed for NJ Ex Order 26.4(b)(1) [redacted]. This deficient practice was evidenced by the following: On 09/03/24 at 7:26 AM, the surveyor entered the facility and was informed by the U.S. FOIA (b) (6) [redacted]) that the facility was in an active outbreak and the last NJ Ex Order 26.4 [redacted] resident (Resident #21) was expected to complete NJ Ex Order 26.4(b)(1) that day. There was signage posted on the front door of the facility and at the receptionist desk that informed visitors that the facility was NJ Ex Order 26.4(b)(1) [redacted] and NJ Ex Order 26.4(b)(1) [redacted] was required. On 09/03/24 at 8:48 AM, the surveyor observed	F 880	1. Resident #21 was evaluated by a licensed nurse with NJ Ex Order 26.4b1 [redacted] of cited event that occurred. A comprehensive COVID Line Listing was implemented and included contact tracing for residents from the outbreak during the previous outbreak by Infection Preventionist on 9/06/2024 . 2. Residents who reside in the facility have the potential to be affected by the cited event. The DON/ Designee conducted an audit of COVID-19-positive residents to validate that contact tracing was conducted and documented and a comprehensive line listing was maintained. 3. The DON/designee re-educated the U.S. FO [redacted] on the facility's COVID-19 Outbreak guidelines and policy including the need to conduct & document contract tracing timely and consistently. 4. The DON/designee will conduct a daily audit of positive cases of COVID-19 to validate that facility policy and local health department guidance were followed to include contract tracing. These audits will be conducted for 3 months. The findings of the audits will be submitted by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 14 Licensed Practical Nurse (LPN) # 1 outside of Resident #21's room during the medication pass. The surveyor observed that there was no signage or NJ Ex Order 26.4(b)(1) to indicate that the resident was on NJ Ex Order 26.4(b)(1). When interviewed, LPN #1 stated that Resident #21 was assigned to her and she did not have any residents who had NJ Ex Order 26.4(b)(1) on her assignment. On 09/03/24 at 9:15 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that Resident #21 was cleared of NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) were discontinued. A review of Resident #21's Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: NJ Ex Order 26.4(b)(, and NJ Ex Order 26.4(b) . The Diagnosis section of the form was later updated on NJ Ex Order 26.4(b), to include a diagnosis of NJ Ex Order 26.4(b)(1) A review of Resident #21's Admission Minimum Data Set (MDS), an assessment tool, revealed that the resident had a Brief Interview for Mental Status score of NJ Ex out of 15 which indicated that the resident was NJ Ex Order 26.4(b)(1). A review of Resident #21's Care Plan revealed an entry dated NJ Ex Order 26.4(b, with a Focus of: I have NJ Ex Order 26.4(b)(1) (resolved NJ Ex Order 26.4(b). Interventions included but were not limited to: NJ Ex Order 26.4(b)(1) per the Federal, State, and local recommendations/regulations... A review of Resident #21's Health Status Note in	F 880	Director of Nurses to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 15	F 880		

the Electronic Health Record (EHR) revealed an entry dated [NJ Ex Order 26.4(b] at 10:14 AM that was documented by the [U.S. FOIA (b] revealed: "The patient NJ Ex Order 26.4(b)(1) The resident is on NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1), he/she is in a single room by his/herself, all services provided in the room. The patient is made comfortable. Will continue plan of care."

On 09/04/24 at 9:38 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that the first resident who NJ Ex Order 26.4(b)(1) or [NJ Ex Order 26.4(], resided on the [NJ Ex Order 26.] in a private room. The [U.S.] stated that she checked to see if the resident had visitors or who the resident NJ Ex Order 26.4(b)(1). The [U.S.] stated that she confirmed that the resident had visitors often. When the surveyor asked the [U.S.] if she completed contact tracing, the [U.S.] stated that she documented notes on the comment section of the line listing (describes an outbreak in terms of person, place and time and allows for quick identification of trends, missing information and errors). The [U.S.] stated she normally used the CDC Checklist and completed contact tracing, "but I have not done it for this [NJ Ex Order 26.4(b] yet." The [U.S.] stated she had to put it together, as her contact tracing is in the comment section of the line listing. The [U.S.] stated, "we are not NJ Ex Order 26.4(b)(1), so I have not put it together yet. I just document on my line listing."

At that time, the [U.S.] stated that on [NJ Ex Order 26.4(b)(], a resident on the [NJ Ex Order 26.] floor NJ Ex Order 26.4(b)(1). The [U.S.] stated the resident had frequent visitors from the outside and had since been discharged to home. The [U.S.] stated on [NJ Ex Order 26.4(b], she was texted at home over the weekend by a nurse and was informed that there were three residents who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 16	F 880		

NJ Ex Order 26.4(b)(1). The U.S. stated that NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) were instituted. The U.S. stated that an NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(, gloves and NJ Ex Order were required to be worn into the affected resident's room.

The U.S. further stated that she notified the local health department official on either Sunday or Monday of the NJ Ex Order 26.4(b)(1). The U.S. stated the official was not available, and someone else responded in her absence. They informed her of a need to start a line list. The U.S. stated that she usually did NJ Ex Order 26.4(b)(1) and symptoms but the NJ Ex Order 26.4(b) stayed in one hallway. She stated, "it may have been from that, it was hard. No one else NJ Ex Order 26.4(b) except for the three residents." The U.S. stated that a fourth resident who was a room mate of a NJ Ex Order 26.4(b)(1), then NJ Ex Order 26.4(b)(1) four days later. The U.S. stated in all, she had eight NJ Ex Order 26.4(b)(1) and one staff member (a house keeper who did not work on either of teh sub-acute units located on the second or fifth floor). The U.S. stated there was another staff member, who does not come to the clinical units and was placed under the "other" tab on the line listing.

At that time, the U.S. stated that a U.S. FOIA (b) (6)) who worked on the NJ Ex Order 26.4(floor NJ Ex Order 26.4(b)(1). The U.S. stated when interviewed, the U.S. FOIA stated that she took care of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 17	F 880		

someone who was ill at home, but did not report that their loved one had [NJ Ex Order 26.4]. The [U.S.] stated that the [U.S. FOIA] came into work early and stated that she felt like she was [NJ Ex Order 26.4(b)(1)] and requested to [NJ Ex Order 26.4(b)(1)] and was sent home early before her shift. The [U.S.] stated the [U.S. FOIA (b)] last day worked was on [NJ Ex Order 26.4]. When the surveyor asked if any staff or residents were tested in response to the [NJ Ex Order 26.4] [U.S. FOIA] the [U.S.] stated that she would have to look and see what assignment the [U.S. FOIA] had. The [U.S.] stated the nurses would notify her if any residents displayed signs and symptoms of [NJ Ex Order 26.4(b)(1)] and nobody was symptomatic at that time. When asked when do you test residents and staff? The [U.S.] stated, "I only test if symptomatic." The [U.S.] further stated "I ask who they were with."

At that time, the [U.S.] stated, "We talk, but it is not documented. It is me yelling at them, where were you, NJ Ex Order 26.4(b)(1)? No testing is done, only residents who were symptomatic were tested and no mass testing was done." The [U.S.] stated, the previous [NJ Ex Order 26.4(b)] (ended on [NJ Ex Order 26.4(b)(1)]), "we [NJ Ex Order 26.4] everybody, because it was out of control." The [U.S.] stated the only [NJ Ex Order 26.4(b)(1)] performed was on the line list and has not been transferred onto my notes yet. The [U.S.] stated [NJ Ex Order 26.4(b)(1)] were done and the results were documented on the resident's charts in the progress notes. The [U.S.] stated right now there are [NJ Ex Order 26.4(b)(1)]. The [U.S.] stated the [NJ Ex Order 26.4(b)] was Resident #21, who [NJ Ex Order 26.4(b)(1)] on [NJ Ex Order 26.4(b)(1)], and was removed from [NJ Ex Order 26.4(b)] on [NJ Ex Order 26.4(b)], on day [NJ Ex Order 26.4(b)] The [U.S.] explained that residents were maintained on [NJ Ex Order 26.4(b)] for [NJ Ex Order 26.4] days. The [U.S.] stated that she had not spoken with Resident #21 about it to determine [NJ Ex Order 26.4(b)(1)].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 18 At that time, the surveyor asked the U.S. if she completed staff or resident education in response to the NJ Ex Order 26.4(b)(1) The U.S. stated "no education that pertained specifically to NJ Ex Order 26.4(b)(1) was completed for this NJ Ex Order 26.4(b)(1) On 09/04/24 at 11:09 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that if signs and symptoms of NJ Ex Order 26.4(b)(1) were exhibited, NJ Ex Order 26 was completed and and the U.S. reached out to the Local Health Department (LHD), U.S. FOIA (b) (6), who directed for NJ Ex Order 26.4(b)(1). The U.S. FOIA stated that her expectation was for the U.S. to pull the staff schedules and review for NJ Ex Order 26.4(b)(1). The U.S. FOIA stated that she was not U.S. certified and relied on the U.S. to work out the details with the LHD. The U.S. FOIA stated that NJ Ex Order 26.4(b)(1) may be documented on the line list. On 09/04/24 at 12:40 PM, the surveyor reviewed the facility line listing provided by the U.S. in her presence, which included eight (8) residents and one (1) staff member (from acute care). The U.S. FOIA who the U.S. stated worked on the NJ Ex Order 26. floor and NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b) , was not included on the line list. Two (2) of the resident's comment sections which the U.S. stated was where she documented NJ Ex Order 26.4(b)(1) were blank with no documented evidence that contact tracing was completed. When the surveyor asked the U.S. why there were blanks on the line listing she stated, "It should have been done." The U.S. further stated that the comment section was intentionally not filled in because a common denominator of NJ Ex Order 26.4(b)(was not found. The surveyor noted that Resident #21 was not included on the line list provided. The U.S. stated that was because the resident had a lot of	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 19 visitors, and was placed under the "other tab". At that time, the [U.S.] stated that on Monday 08/19/24, she sent the line list to the LHD. When the surveyor asked why she waited until 08/19/24 to inform the LHD, the [U.S.] stated, "It took three residents to [NJ Ex Order 26.4(b)(1)]." The [U.S.] further stated, The definition of an [NJ Ex Order 26.4(b] was: "two or more staff or residents with [NJ Ex Order 26.4(b)(1)]." At that time, the surveyor reviewed an email correspondence between the [U.S.] and the Health Department dated 08/21/24 at 9:39 AM, which included the following guidance for the [U.S.] to institute: ...Conduct contact tracing on all resident and staff cases, Conduct testing of close contacts (someone who is within six feet of a COVID-19 case for a cumulative total of 15 minutes or more over a 24-hour period during the COVID-19 case's infectious period) as appropriate (on days 1, 3, and 5), If the facility is unable to perform contact tracing, broad based testing of the unit/wing/facility can be conducted (every 3-7 days until no new cases are found for 14 days), Be sure to follow all applicable federal and state directives. Outbreak Documentation: ...Template: COVID-19 Facility Line List Template Include only residents and staff associated with this current outbreak. Be sure to add non-facility onset cases to the "other cases" tab on the line list after consulting with the LHD. At that time, the surveyor asked the [U.S.] to define [NJ Ex Order 26.4(b)(1)] she stated, "Anyone who spent more than five minutes with a resident with care	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 20	F 880		

within a three to five feet distance." There was no documented evidence reflected on the line listing in the comment section to indicate that the [U.S.] interviewed both staff and residents who [NJ Ex Order 2] [redacted] or, visited or rendered care to the affected individuals to determine any [NJ Ex Orde] [redacted] who may have been exposed to the positive individuals to prevent the further spread of [NJ Ex Order 26.4(b)(1)].

On 09/04/24 at 1:05 PM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted] regarding the [U.S. FO] documentation of NJ Ex Order 26.4(b)(1) that was noted on the comment section of the line list. The [U.S. FOIA (b)] stated, "I would expect more information to have been provided." The [U.S. FOIA (b)] stated that she would have included: known or potential [NJ Ex Order 26.4(b)(1)] additional [NJ Ex O] [redacted], [NJ Ex Order 26.4(b)(1)] and findings, activities, underlying conditions etc." The [U.S. FOIA (b)] stated that the [NJ E] can document [NJ Ex Order 26.4(b)(1)] on the line list, but it has to be more comprehensive. The [NJ Ex Order 2] stated, "If proper contact tracing was not done, there could be NJ Ex Order 26.4(b)(1)

On 09/04/24 at 11:22 AM, the surveyor interviewed the [NJ Ex Orde] who stated, "I expect the line list to be comprehensive and include all residents with [NJ Ex Order 26.4(b)] The [U.S. FOIA (b)] stated that if the [U.S.] did contact tracing and did not document it, that was an issue.

On 09/04/24 at 3:49 PM, the [U.S. FOIA (b)] provided the surveyor with a copy of the line listing via e-mail. The surveyor reviewed the line listing and noted that Resident #21 was added to the line listing after surveyor inquiry. The surveyor reviewed Resident #21's comment section of the line listing which revealed the following: NJ Ex Order 26.4(b)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 21	F 880		

from an unsampled resident, (who was also on the line listing as NJ Ex Order 26.4(b)(1)), residents observed conversing prior days.

A review of the facility policy, "Contact Tracing-Residents" (Updated 07/2023) revealed the following: Contact tracing is a method of identifying those who may have been exposed to COVID-19, to help track and prevent the transmission of COVID-19.
Close contact (exposure) is defined by the CDC as being within 6 (six) feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period.

Procedure: Identify the infectious period for the resident. An infectious period begins 2 (two) days prior to symptom onset, if symptomatic.
If asymptomatic, the infectious period is calculated as 2 (two) days prior to the COVID-19 specimen collection date.
Add 10 (ten) days from the start of the identified infectious period, to determine the end date of the infectious period.
For each day of the infectious period, identify all locations the resident visited within the facility (e.g., resident room, dining room, activity room) or if the resident was hospitalized or in another facility (e.g., hospital and unit, dialysis facility).
For each location, make notes about each person that could have been in contact with the resident including visitors, other residents, staff, and volunteers.
Identify contacts at each location for each day during the infectious period.
For each person exposed, investigate the interaction between the case-person and the exposed contact.
Was the resident wearing a mask?, Was the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 22	F 880		

resident able to wear the mask consistently? , Was the resident coughing?, What was the nature of the interaction?, How close were the case-person and the exposed person?, For any of the interactions, was the exposed person wearing a mask or other appropriate PPE? Determine if exposed persons meet the definition of a close contact. A person in close contact with the case-patient during the symptomatic period would be considered exposed.
Notify all exposed persons of their exposure and the required monitoring and quarantine restrictions.

A "COVID-19 Resident Contact Tracing Tool" and "Contact Tracing Location Tracker" were attached to the policy. Also attached to the policy was a "COVID-19 Resident Contact Tracing Tool" which was not utilized by the IP to determine potential exposures that may have occurred at the facility.

A review of the facility policy, "CDC Guidance-New Infection in Healthcare Personnel or Resident" (Revised 09/24/22) revealed the following:

The facility will review and implement recommendations by the CDC. Regulatory guidance and/or directives provided by the State and or CMS (Centers for Medicare and Medicaid Services) may supersede the CDC recommendations.

A single new case of SARS-CoV-2 infection in any healthcare personnel (HCP) or resident should be evaluated to determine if others in the facility could have been exposed.

The approach to an outbreak investigation could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 23 involve either contact tracing or a broad based approach; however, a broad-based (e.g., unit, floor, or other specific areas of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (one) (where day of exposure is day 0), day 3 (three) and day 5 (five). NJAC 8:39-19.4 (a)(d)(f)(g)	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and review of other pertinent facility documentation, it was determined that the facility failed to ensure full implementation of the NJ Ex Order 26.4(b) stewardship program, including ongoing	F 881	1. Resident # 27 was evaluated by the DON on 9/18/2024 with NJ Ex Order 26.4(b)(1) were identified related to the cited event.	9/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 881	Continued From page 24 NJ Ex Order 26.4(b)(1) and use of a nationally recognized surveillance criteria prior to consulting the prescriber. This deficient practice was identified for 1 of 1 resident reviewed for NJ Ex Order 26.4(b) stewardship, (Resident #27). This deficient practice was evidenced by the following: On 09/04/24 at 9:38 AM, the surveyor interviewed the U.S. FOIA (b) (6) regarding the facility NJ Ex Order 26.4(b) Stewardship Program (efforts to ensure that NJ Ex Order 26.4(b)(1) are used only when necessary and appropriate). The U.S. stated that she had worked at the facility for nearly NJ Ex Order 26.4(b) and had worked as an U.S. since NJ Ex Order When the surveyor asked the U.S. to describe how the NJ Ex Order 26.4(b) Stewardship Program worked she stated, "With a prayer." The U.S. stated that she monitored residents on NJ Ex Order 26.4(b)(1) When the surveyor requested to view the NJ Ex Order 26.4(b) Stewardship documentation, the U.S. stated that she would need to run a report in order to do so. When the surveyor asked the U.S. to run the report, the U.S. stated that she would have to get back to the surveyor at a later time with that information. The U.S. stated that she reviewed the NJ Ex Order 26.4(b) Stewardship Program recently with both the Medical Director and Administrator at a Quality Assurance Performance Improvement. (QAPI) meeting. At that time, the U.S. stated that she used the NJ Ex Order 26.4(Criteria [used for retrospectively counting NJ Ex Order 26.4(b)(1), with more diagnostic information (NJ Ex Order 26.4(b)(1) often used to meet the criteria for NJ Ex Order 26.4(b)(1))]. The U.S. stated that	F 881	2. Current residents who are prescribed antibiotic therapy have the potential to be affected by the cited event. The DON/designee audited current residents receiving Antibiotic Therapy to validate that facility policy on ABT stewardship was followed and that the appropriate criteria were met. Variances were addressed. 3. The DON/designee re-educated the US FOIA on the facility Infection Control Antibiotic Stewardship Program and the need to validate McGreer or Lobes criteria is followed. The ICP/designee re-educated Licensed Nurses on the Infection Control Antibiotic Stewardship Program and the need to follow the McGreer or Lobes criteria. 4. The DON/designee will audit 3 residents receiving Antibiotic therapy to validate that facility policy on ABT stewardship was followed and that the appropriate criteria were met. Variances will be addressed. These audits will be completed weekly x 4 weeks and monthly x 2 months. The findings of the audits will be submitted by the Director of Nursing to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 881	Continued From page 25	F 881		

there was a tool in the computer system, but the nurses did not always complete it. The U.S. stated that if she had time, she went into the computer and completed the tool. When the surveyor asked the U.S. to demonstrate use of the tool within the computer that was on her desk in front of her, she stated that the report would need to be ran from the electronic health record. The surveyor asked the U.S. to identify a resident who was currently being monitored for the NJ Ex Order 26.4(b) stewardship and the U.S. stated, "I cannot tell you right now." The U.S. stated that she ensured the appropriate usage of a prescribed NJ Ex Order 26.4(b) was met with the NJ Ex Order 26.4(Criteria Assessment. The U.S. stated that if the NJ Ex Order 26.4(Criteria was not met, she reached out to the doctor and asked if changes could be made. When the surveyor asked the U.S. to provide a list of residents who currently received NJ Ex Order 26.4(b)(1 at the facility, or an example of the NJ Ex Order 26.4(Criteria Assessment template in her computer or elsewhere, the U.S. was unable to provide the surveyor with documented evidence of completion of any component of an NJ Ex Order 26.4(b) Stewardship Program.

On 09/04/24 at 1:05 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated that NJ Ex Order 26.4(b) Stewardship was reviewed during QAPI meetings. The U.S. FOIA (b) stated that the U.S. should have been able to provide evidence of the facility NJ Ex Order 26.4(b) Stewardship Program when requested. The U.S. FOIA (b) stated that she would look within the QAPI Binder.

On 09/05/24 at 9:29 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that when a resident demonstrated signs and symptoms of an NJ Ex Order 26.4(she first evaluated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 881	Continued From page 26	F 881		

signs and symptoms of the NJ Ex Order 26.4(b and then notified the doctor. LPN #1 stated that if the resident had a NJ Ex Order 26.4(b)(1), the doctor may order a NJ Ex Order 26.4(b)(1) or a NJ Ex Order 26.4(b)(1), or if the resident were NJ Ex Order 26.4(b) the doctor may order a NJ Ex Order 26.4(b)(1). LPN #1 stated if an NJ Ex Order 26.4(b) was ordered, she started it as soon as possible and informed both the resident and the resident's family. LPN #1 stated that no additional documentation or notification were required when a new NJ Ex Order 26.4b1 treatment was ordered.

On 09/05/24 at 11:22 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated that the facility reviewed resident NJ Exec Order 26.4b usage at QAPI Meetings and clinical meetings. The U.S. FOIA stated that when an NJ Ex Order 26.4(b) was ordered, the nurse should document, review signs and symptoms, see why the NJ Ex Order 26.4(b) was ordered, and then update the resident's care plan. The U.S. FOIA stated that the U.S. did the NJ Ex Order 26.4(Criteria and there must be two symptoms present. The U.S. FOIA stated that she was unsure if the nurses were required to complete the NJ Ex Order 26.4(Criteria. The U.S. FOIA stated that she would have expected that the U.S. would have shown the surveyor her NJ Ex Order 26.4(b) Stewardship when requested and should have known of at least one resident who received an NJ Ex Order 26.4(b) when asked. The U.S. FOIA stated the U.S. should have had a binder with the information requested in her office. The U.S. FOIA further stated that she was not an U.S. F but she knew who the residents were who received antibiotics.

On 09/05/24 at 12:06 PM, the U.S. FOIA (b) stated that she was ultimately responsible for oversight of the U.S. FO work, and agreed to furnish the surveyor with a binder used for NJ Ex Order 26.4(b) Stewardship.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 881	Continued From page 27 On 09/05/24 at 1:17 PM, in a later interview with the U.S. FOIA (b) she provided the surveyor with a binder used for NJ Ex Order 26.4(b) Stewardship and stated that the information was used during QAPI meetings. When the surveyor asked why the binder only contained laboratory data and reports that were obtained from the electronic health record (EHR) that pertained to NJ Ex Order 26.4(b) usage and failed to contain documented evidence of NJ Ex Order 26.4(Criteria Assessments, the U.S. FOIA (b) stated that there was more education that needed to be done with the U.S. F On 09/06/24 at 10:01 AM, in the presence of the survey team, the U.S. FOIA stated that after an NJ Ex Order 26.4(b) was started, the nurse filled out the NJ Ex Order 26.4(screening evaluation. The U.S. FOIA explained that the U.S. FOIA (b) (6) provided an order for NJ Ex Order 26.4(b)(1) and the U.S. FOIA (b) (6)) Doctor did the screening and confirmed that the NJ Ex Order 26.4(b) was appropriate and there was no resistance to the NJ Ex Order 26.4(b)(The U.S. FOIA stated that the U.S. was responsible for reviewing the NJ Ex Order 26.4(b) Stewardship and she should have been documenting in the EHR and also should have been tracking NJ Ex Order 26.4(b) usage. The U.S. FOIA stated that the monthly tracking that was provided within the binder was completed by the laboratory. On 09/06/24 at 10:07 AM, the U.S. FOIA (b) stated that the facility reviewed NJ Ex Order 26.4(b) usage both daily and monthly. When asked how the facility ensured appropriate NJ Ex Order 26.4(b) usage, the U.S. FOIA (b) stated that labs and symptoms were reviewed. The U.S. FOIA (b) stated that documentation of daily tracking was not maintained and only monthly tracking provided by the lab was kept.	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 881	Continued From page 28	F 881		

On 09/06/24 at 10:13 AM, the [U.S.] stated that she was tracking [NJ Ex Order 26.4(b)] usage in the EHR that were prescribed both from the hospital and in house. The [U.S.] stated that she spoke with the nurses to track changes if any changes were identified during the daily meeting. The [U.S.] stated the staff nurse would complete the assessment form and determine if the [NJ Ex Order 26.4(b)] criteria was met within three days of a resident starting an antibiotic. The [U.S.] stated that if the [NJ Ex Order 26.4(b)] criteria was not met, then the doctor was notified and the [NJ Ex Order 26.4(b)] was discontinued. When the surveyor asked if [NJ Ex Order 26.4(b)] stewardship should have been reviewed prior and what the process was to determine if an [NJ Ex Order 26.4(b)] were appropriate prior to administration, the [U.S.] stated that she reviewed [NJ Ex Order 26.4(b)] Stewardship in daily clinical meetings. The [U.S.] stated that she reviewed the information prior to presenting. When the surveyor asked the [U.S.] how she could have explained resident information fully if there was missing documentation on the assessment forms that were provided to the survey team, the [NJ E] stated, "I will go off memory" to try and fill out the information that was missing. The [NJ E] further stated that she did not document daily when the daily meetings were held, as they just discussed it.

At that time, the [U.S.] stated the importance of [NJ Ex Order 26.4(b)] Stewardship was to identify infections and "how we can discuss whether the antibiotics that were used were effective or not."

On 09/06/24 at 4:42 PM, the [U.S. FOIA (b)] provided the surveyor with a list of residents who received [NJ Ex Order 26.4(b)(1)] in-house for the past three months. The surveyor reviewed the list and noted that Resident #27 was included on the list. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 881	Continued From page 29	F 881		

surveyor reviewed the Medication Administration Record (MAR) within the resident's EHR which revealed that on NJ Ex Order 26.4(b at 9:00 AM, the NJ Ex Order 26.4(b)(1) Give 1 (one) tablet via NJ Ex Orde NJ Ex Order 26.4 NJ Ex Orde every 12 hours for NJ Ex Order 26.4(b)(1) for 2 (two) days. On NJ Ex Order 26.4(b at 1644 (4:44 PM), the order was discontinued and revised for the same dosage and the indication of NJ Ex Order 26.4(b)(1) was replaced the indication of NJ Ex Order 26.4(b)(1) which was omitted. The order had a start date of NJ Ex Order 26.4(b)(at 2100 (9:00 PM) and an end date of NJ Ex Order 26.4(b at 23:59 (11:59 PM). A review of the MAR indicated that the resident received a dosage of the medication at 9:00 PM as ordered and on NJ Ex Order 26.4(b at 9:00 AM. Further review of the MAR revealed that there were blanks on the MAR on NJ Ex Order 26.4(b at 9:00 PM , and there were also blanks for the medication administration times that pertained to NJ Ex Order 26.4(b at both 9:00 AM and 9:00 PM, with no documentation provided into the allotted spaces to indicate the status of NJ Ex Order 26.4(b administration through the end date of NJ Ex Order 26.4(b at 23:59 (11:59 PM).

A review of Resident #27's Physician Progress Note dated NJ Ex Order 26.4(b at 1517 (3:17 PM) revealed a "First Docs Readmission Note", which indicated ...the resident was readmitted to the facility after he/she was sent out to NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(for NJ Ex Order 26.4(b)(1) ... NJ Ex Order 26.4(b)(1) administered for NJ Ex Order 26.4(b)(1) [sic]..." Further review of the Progress Notes (PN) failed to contain a notation that referred to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 881	Continued From page 30 an order for [redacted]) Give 1 (one) tablet via [redacted] every 12 hours for [redacted] for 2 (two) days. A review of a PN dated [redacted] at 1458 (2:58 PM) resident was sent to the hospital. On [redacted] a 22:54 (10:54 PM), a Discharge Summary note revealed that ...was told by ER Nurse patient admitted with [redacted]...Further review of the EHR revealed that on [redacted] at 23:56 (11:56 PM), an Admission Summary note revealed that the resident arrived back to the facility from the hospital via [redacted] Review of the facility policy, "Antibiotic Stewardship" (Revised 12/2016) revealed the following: Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. Orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community. ...When a resident is admitted from an emergency department, acute care facility, or other care facility, the admitting nurse will review	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 881	Continued From page 31	F 881		

discharge and transfer paperwork for current antibiotic/anti-infective orders.

Discharge or transfer medical records must include all of the above drug and dosing elements...

...As soon as clinically appropriate, the prescriber will be asked to review converting parenteral (administered elsewhere in the body other than the mouth) antibiotics to an oral formulation.

Review of the facility policy, "Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes (Revised 12/2016) revealed the following:

Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide the decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship.

As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection Preventionist, or designee.

The IP, or designee will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics.
a. Therapy may require further review and possible changes if:
the organism is not susceptible to antibiotic chosen;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 881	Continued From page 32 the organism is susceptible to narrower spectrum antibiotic; therapy was ordered for prolonged surgical prophylaxis; or Therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics... ..All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form... NJAC 8:39-19.4(c) (d)	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21126L	A. BUILDING: _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 Complaint #: NJ169579 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ169579 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey, for 6 of 6 weeks of staffing prior to the recertification survey date of 09/06/2024. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health	S 560	1. No residents were identified as having been affected. 2. All residents have the potential to be affected. 3. The Director of Nursing, Staffing Coordinator and NHA will meet daily during the week to review daily and weekly staffing, recruitment efforts and trends. Trends identified from these meetings will be presented during monthly QAPI meeting.	9/30/24

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

Electronically Signed | 09/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21126L	A. BUILDING: _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) 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 (1) 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. A review of the "Nurse Staffing Report" for the following weeks provided by the facility revealed the following: 1. For the 2 weeks of Complaint staffing from 11/19/2023 to 12/02/2023, the facility was deficient in CNA staffing for residents on 7 of 14-day shifts, and deficient in CNAs to total staff on 1 of 14 evening shifts as follows: -11/19/23 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -11/24/23 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs. -11/24/23 had 3 CNAs to 8 total staff on the	S 560	4. The facility has implemented a 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, Campaign to rehire staff that have resigned, Rate adjustments, Benefit adjustments, Text message campaigns. 5. The facility has developed a Culture Committee focused on staff retention 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 and doing Employee of the Month. The facility also has seasonal holiday parties, gives all employees presents during each holiday season and celebrates all employee birthdays once a month. 6. The facility participates in a weekly interdisciplinary Recruitment Call with consultants to review open positions, recruitment tactics, and changes to improve outcomes. The facility conducts an exit meeting with any employee who resigns to better improve the employee experience and help with retention. Monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21126L	A. BUILDING: _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 evening shift, required at least 4 CNAs. -11/25/23 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs. -11/26/23 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs. -11/27/23 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs. -11/28/23 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. -12/02/23 had 4 CNAs for 51 residents on the day shift, required at least 6 CNAs. 2. For the 2 weeks of Complaint staffing from 12/24/2023 to 01/06/2024, the facility was deficient in CNA staffing for residents on 5 of 14-day shifts, and deficient in CNAs to total staff on 1 of 14 evening shifts as follows: -12/24/23 had 4 CNAs for 51 residents on the day shift, required at least 6 CNAs. -12/26/23 had 4 CNAs for 51 residents on the day shift, required at least 6 CNAs. -12/31/23 had 4 CNAs for 43 residents on the day shift, required at least 5 CNAs. -12/31/23 had 4 CNAs to 10 total staff on the evening shift, required at least 5 CNAs. -01/02/24 had 4 CNAs for 43 residents on the day shift, required at least 5 CNAs. -01/06/24 had 4 CNAs for 47 residents on the day shift, required at least 6 CNAs. 3. For the 2 weeks of staffing prior to survey from 08/18/2024 to 08/31/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -08/18/24 had 4 CNAs for 56 residents on the day shift, required at least 7 CNAs.	S 560	1. NHA/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 2months 2. NHA/designee will interview five residents weekly for 4 weeks and then monthly for an additional 2 months to determine if needs are being met. 3. 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 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
	21126L	A. BUILDING: _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 -08/19/24 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -08/20/24 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -08/21/24 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -08/22/24 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -08/23/24 had 5 CNAs for 54 residents on the day shift, required at least 7 CNAs. -08/24/24 had 4 CNAs for 54 residents on the day shift, required at least 7 CNAs. -08/25/24 had 4 CNAs for 54 residents on the day shift, required at least 7 CNAs. -08/26/24 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs. -08/28/24 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs. On 09/05/24 at 10:46 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the staffing coordinator was off that day. The LNHA stated that she was aware of the mandated staffing ratios, and she reviews the staffing with the staffing coordinator.	S 560		
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year,	S1410		9/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21126L	A. BUILDING: _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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
S1410	Continued From page 4 employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility records, it was determined that the facility failed to ensure that a new employee received the [NJ Ex Order 26.4(b)(1)]), also called a NJ Ex Order 26.4(b)(1)), as required for 2 of 10 newly hired employee files reviewed. The deficient practice was evidenced by the following: The surveyor reviewed the employee health files of ten random newly hired employees since the last recertification survey date of 06/02/23, which revealed the following: -Employee #7, with a hire date of [NJ Ex Order 26.4(b)], had an Employee NJ Ex Order 26.4(b)(1)	S1410	1. No specific resident(s) were identified by the cited event. Employee #7 is no longer employed at the facility. Employee #9 is no longer employed at the facility. 2. An audit was completed of employee files by HR and ICP on 9/20/2024 to validate that a 2-step PPD was completed and documented per policy. Variances were addressed. 3. The Director of Nursing & Director of Infection Control re-educated the [US FOIA] on the employee PPD policy. 4. The DON/designee will audit 3 new employee files weekly to validate that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21126L	A. BUILDING: _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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
S1410	Continued From page 5 form in their file with a NJ Ex Order 26.4(b)(1) documented as administered on NJ Ex Order 26.4(b) and the NJ Ex Order 26.4(b) was not documented as administered. -Employee #9, with a hire date of NJ Ex Order 26.4(b), had an Employee NJ Ex Order 26.4(b)(1) form in their file with a NJ Ex Order 26.4(b)(1) documented as administered on NJ Ex Order 26.4(b) and the NJ Ex Order 26.4(b) was not documented as administered. During an interview with the surveyor on 09/06/24 at 8:41 AM, the Licensed Nursing Home Administrator (LNHA) reviewed the NJ Exec Order 26.4 Screening form for Employee #7 and #9 and confirmed the NJ Ex Order 26.4(b)(1) were documented as administered on NJ Ex Order 26.4(b) and read as NJ Ex Order 26.4(b) on NJ Ex Order 26.4(b). The LNHA confirmed that the NJ Ex Order 26.4(b)(1) were not documented as administered for Employee #7 and #9. During an interview with the surveyor on 09/06/24 at 8:58 AM, the Infection Preventionist (IP) stated that new hires required a NJ Ex Order 26.4(b)(1). The NJ Ex O would have been given at orientation on Wednesdays, then the employees were asked to return 2 days later, on a Friday, to have the results read. The newly hired employees were then asked to return in two weeks on a Wednesday to get their NJ Ex Order 26.4(b)(1) and then return in 48 hours for their NJ Ex Ord to be read. The IP confirmed she administered the NJ Ex Order 26.4(b)(1) to Employee #7 and #9 which were read as negative, and that these two employees did not receive the NJ Ex Order 26.4(b)(1). The IP stated it was important to test for NJ Ex to see if anyone had any exposure to NJ Ex Order 26.4(b)(1) A review of the facility's policy titled, "Tuberculosis, Employee Screening-New Jersey," updated May 2023, revealed that all employees	S1410	PPD policy was followed. Variances will be addressed. These audits will be completed weekly x 4 weeks and monthly x 2 months. The findings of the audits will be submitted by the Director of Nurses to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21126L	A. BUILDING: _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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
S1410	Continued From page 6 are screened for latent and active Tuberculosis (TB) disease prior to initial employment. All new employees should receive a two-step Mantoux tuberculin skin test (TST) upon hire and the results of the Mantoux TST test shall be read 48-72 hours after administration and acted upon as follows: a. If the first step of the TST result is negative, the second step will be administered one to three weeks after the first result is read. b. If the TST result is significant (10 milliliters or more of duration), they should receive a symptom evaluation and chest X-ray to rule out active TB disease. No second TST is needed.	S1410		

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
315127 Y1	A. Building B. Wing Y2	10/7/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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 F0658	Correction	ID Prefix F0812	Correction	ID Prefix F0865	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)	Completed
LSC	09/30/2024	LSC	09/30/2024	LSC	09/30/2024
ID Prefix F0880	Correction	ID Prefix F0881	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(a)(3)	Completed	Reg. #	Completed
LSC	10/07/2024	LSC	09/30/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/6/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
21126L (Y1)	(Y2)	10/7/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD LAWRENCEVILLE, NJ 08648

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/30/2024	ID Prefix S1410 Reg. # 8:39-19.5(b)(1) LSC	Correction Completed 09/30/2024	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 9/5/2024 and 9/6/2024, and Lawrence Rehabilitation Hospital was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Lawrence Rehabilitation Hospital is a six-story building that was built in 1971. It is composed of Type II protected construction. The facility is divided into ten smoke zones. The generator does approximately 100 % of the building as per The Maintenance Director and Regional Plant Operations Director.	K 000		
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	K 225		10/13/24

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

Electronically Signed | 09/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **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
K 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/5/2024 in the presence of the[U.S. FOIA (b) (6)]) and [U.S. FOIA (b) (6)]), it was determined that the facility failed to ensure that exit stair landings and exit stair handrails were marked in accordance with NFPA 101:2012 Edition, Sections 19.2.2.3, 7.2.2.5.5.2, and 7.2.2.5.5.3. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations during the tour between 8:15 AM and 3:48 PM in the presence of the [U.S. FO] and [U.S. FOIA (b) (6)] revealed 5 of 6 exit stairways had no marking stripes on the steps and the upper surface of the handrails were not marked as required by the Code. In an interview at that time, the [U.S. FO] and [U.S. FOIA (b)] confirmed the observation. The facility's [U.S. FOIA (b) (6)] was notified of the deficient practice at Life Safety Code exit conference on 09/06/2024 at 3:38 PM. NJAC 8:39 31.2 (e)	K 225	1. Maintenance Director or Designee will Paint all three tower stairwells. This will include stair treads, border of stair landings and handrails with the color of safety yellow. Painting was started 9/25/24 and will continue by completion date of 10/13/24. 2. All residents have the potential to be affected. 3. The [U.S. FOIA (b) (6)] was educated by the Regional Director of Plant operations on the requirement of ensuring the stair treads, border of stair landings and handrails with the color of the safety yellow marked in accordance with NFPA 101: 2012 edition, Sections 19.2.2.3, 7.2.2.5.5.2 and 7.2.2.5.5.3 4. The Plant Operation Manager will audit conduct an audit monthly x 3 months to ensure that exit stair landings and exit stair handrails are marked in accordance with NFPA 101: 2012 edition, Sections 19.2.2.3, 7.2.2.5.5.2 and 7.2.2.5.5.3. 5. The contents of the audit above will be reported by the Plant Operations Manager or his designee and reviewed at the quarterly QA meeting by the administrator or designee with suggested recommendations made by the committee.	
K 353 SS=F	Sprinkler System - Maintenance and Testing	K 353		10/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **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
K 353	Continued From page 2 CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews on 09/06/2024 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) , it was determined that the facility failed to ensure that a fire sprinkler system 5-year internal obstruction investigation was conducted in accordance with NFPA 101: 2012 Edition, Sections 9.7.5, 9.7.7 and NFPA 25. This deficient practice had the potential to affect all residents and was evidenced by the following: Documentation review at 8:00 AM, revealed that the last 5-year Internal obstruction investigation for fire sprinkler system was conducted on 07/26/2019, more than 5-years earlier. No documentation was provided regarding a current	K 353	1) The fire inspection vendor will conduct fire sprinkler system 5-year internal obstruction investigation on 10/17/2024 . Maintenance Director or Designee will ensure timeliness of the Fire Company inspections and ensure documentation is available onsite. 2) All residents have the potential to be affected. 3) The U.S. FOIA (b) (6) was educated by the Regional Director of Plant operations on the requirement of ensuring the fire sprinkler system 5-year internal obstruction investigation is completed and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **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
K 353	Continued From page 3 inspection. In an interview at the time, the U.S. FO and U.S. FOIA (b) confirmed the findings. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at Life Safety Code exit conference at 3:38 PM. N.J.A.C 8:39-31.2(e) NFPA 25	K 353	results available on site for inspection in accordance with NFPA 101,2012 edition, Sections 9.7.5, 9.7.7, NFPA 25 4) Maintenance Director will audit annually to ensure that a fire sprinkler system 5 year internal obstruction investigation is conducted in accordance with NFPA 101,2012 edition, Sections 9.7.5, 9.7.7, NFPA 25 5) The contents of the audit above will be reported by the Maintenance Director or his designee and reviewed at the quarterly QA meeting by the Administrator or designee with suggested recommendations made by the committee.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided	K 363		9/7/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **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
K 363	Continued From page 4 with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/05/2024 in the presence of the U.S. FOIA (b) (6) [redacted]) and U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance NFPA 101: 2012 Edition, Sections 19.3.6, 19.3.6.3, 19.6.3.1 and 19.6.5. This deficient practice had the potential to affect residents in 4 rooms and was evidenced by the following: Observations during the tour from 9:15 AM to 3:30 PM in the presence of the U.S. FO [redacted] and U.S. FOIA (b) (6) [redacted] revealed the following: 1. Resident room #526 was stuck at the bottom	K 363	1) The resident room door in room #526 was repaired and tested on 9/6/2024. The double doors between rooms #524 and #522 were repaired and tested on 9/6/2024. The double doors next to room 520 was repaired and tested on 9/6/2024. 2) All residents have the potential to be affected. 3) The Regional Director of Plant Operations educated the U.S. FOIA (b) (6) [redacted] on the requirement to ensure that corridor doors are able to resist the passage of smoke in accordance with NFPA 101,2012 edition, Sections 19.3.6, 19.3.6.3, 19.6.3.1, 19.6.5.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **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
K 363	Continued From page 5 when tested by the U.S. FOIA 2. The double doors between room #524 and room #522 were rubbing the frame and not closing when tested by the U.S. FOIA 3. The double doors next to room #520 had a gap between doors when tested by the U.S. FOIA In an interview at that time, the U.S. FOIA and U.S. FOIA (b) confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at Life Safety Code exit conference on 09/06/2024 at 3:38 PM. NJAC 8:39-31.1(c), 31.2(e)	K 363	4) Maintenance Director will audit weekly x 4 and then monthly x 2 to ensure that corridor doors are able to resist the passage of smoke in accordance with NFPA 101,2012 edition, Sections 19.3.6, 19.3.6.3, 19.6.3.1, 19.6.5. 5) The contents of the audit above will be reported by the Maintenance Director or his designee and reviewed at the quarterly QA meeting by the Administrator or designee with suggested recommendations made by the committee.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/05/2024 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) , it was determined that the facility failed to ensure resident bathroom	K 521	1) The electrical company will be repairing the rooftop exhaust vents. This will correct the ventilation issues in resident bathrooms that were indicated. Maintenance Director or Designee will	11/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **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
K 521	Continued From page 6 ventilation systems for 12 of 54 units were functionally maintained in accordance with the National Fire Protection Association (NFPA) 90 A. This deficient practice was evidenced by the following: Observations throughout a tour of the facility in the presence of the (b) (9) and U.S. FOIA revealed that the ventilation in the following resident room bathrooms were not functioning: Room #206, 208,220c ,227, 229, 503, 507, 509, 510,512, 514 and 523 The surveyor requested that the U.S. FO confirm if the units were functioning. When tested by placing a piece of single-ply toilet tissue paper across the ceiling grills, the tissues were not held in place by any suction. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. In an interview at the time, the U.S. FO and U.S. FOIA (b) confirmed that the exhaust vents in the above resident room bathrooms were not functioning. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at Life Safety Code survey exit conference on 09/06/2024 at 03:38 PM. NJAC 8:39-31.2(e) NFPA 90 A	K 521	ensure the repair is completed and will test that they are functioning properly. 2) All residents have the potential to be affected. 3) The Regional Director of Plant Operations educated the U.S. FOIA (b) (6) on the requirement to ensure that resident bathroom ventilation systems are functionally maintained in accordance with NFPA NJAC 8:39-31.2(e) NFPA 90 4) Maintenance Director will audit weekly x 4 and monthly x 3 to ensure resident bathroom ventilation systems are functionally maintained in accordance with the NFPA 90A 5) The contents of the audit above will be reported by the Maintenance Director or his designee and reviewed at the quarterly QA meeting by the Administrator or designee with suggested recommendations made by the committee.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4.	K 531		11/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **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
K 531	Continued From page 7 Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/5/2024 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to maintain elevator emergency communication telephones for 1 of 3 elevator telephones tested in accordance with ASME/ANSI A17.3. This deficient practice had the potential to affect all residents and was evidenced by the following: At 10:17 AM, the U.S. FO conducted a test of the emergency communication telephone system for elevator #2. The emergency telephone did not function when the button was activated. In an interview at that time, the U.S. FO and U.S. FOIA (b) confirmed the emergency communication telephone in elevator #2 did not function when tested.	K 531	1) The emergency communication telephone system for elevator #2 will be repaired by a licensed contractor on 10/9/2024. Maintenance Director or Designee will ensure the repair is completed and will test that they are functioning properly. 2) All residents have the potential to be affected. 3) The Regional Director of Plant Operations educated the U.S. FOIA (b) (6) on the requirements for elevator emergency communication telephone maintenance in accordance with ASME/ ANSI A17.3. 4) The Plant Operation Manager will audit monthly x 3 to ensure elevator emergency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **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
K 531	Continued From page 8 The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code exit conference on 09/6/2024 and 3:38 PM. NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531	communication telephones are maintained in accordance with ASME/ ANSI A17.3. 5) The contents of the audit above will be reported by the Plant Operations Manager or his designee and reviewed at the quarterly QA meeting by the administrator or designee with suggested recommendations made by the committee.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 914		10/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **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
K 914	Continued From page 9 Based on documentation review and interview on 9/5/2024 in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that the electrical system was maintained in accordance with NFPA 99 (2012 edition) Health Care Facilities Code section 6.3.4.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Documentation review of the Electrical Inspection for 2024, provided by the U.S. FOI revealed the electrical report dated 07/21/2024 identified the following: 1. HVAC #4 control panel circuit 43A had a poor crimp connection. "Repair Immediately". 2. Main breaker for LVRP2C section 1 phase A, had a loosed wire connection. "Repair Immediately". No documentation was provided for repairs to these identified conditions. In an interview at the time, the U.S. FO and U.S. FOIA (b) confirmed the findings. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at Life Safety Code Survey exit conference on 09/06/2024 at 3:38 PM. NJAC 8:39-31.2(e) NFPA 99	K 914	1. The electrical contactor in HVAC unit #4 will be repaired by a licensed HVAC company. Maintenance/Designee will ensure the repair is completed and will test that the unit is functioning properly. The Main breaker for LVRP2C section 1 phase A had a loose wire connection that has been repaired. 2. All residents have the potential to be affected. 3. The U.S. FOIA (b) (6) was educated by the Regional Director of Plant operations on the requirement of ensuring that electrical system is maintained in accordance with NFPA 99, 2012 edition Health Care Facilities Code section 6.3.4.1 4. Maintenance Director will audit quarterly x 4 to ensure that electrical system is maintained in accordance with NFPA 99, 2012 edition Health Care Facilities Code section 6.3.4.1 5. The contents of the audit above will be reported by the Maintenance Director or his designee and reviewed at the quarterly QA meeting by the administrator or designee with suggested recommendations made by the committee.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		10/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **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
K 918	Continued From page 10 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 9/5/2024 in the presence of the U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6)	K 918	1. The generator diesel fuel that was deemed abnormal will be polished, cleaned and reintroduced back into the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **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
K 918	Continued From page 11 U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that the emergency and standby power generator diesel fuel quality was maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.3.8. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility's generator report dated 01/11/ 2024, provided by the U.S. FOI revealed a diesel fuel sample analysis indicated an abnormal fuel condition. The water and sediment content were high. In an interview at that time, the U.S. FO and U.S. FOIA (b) confirmed the findings. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at Life Safety Code Survey exit conference on 09/06/2024 at 3:38 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	tank by a licensed fuel company. Once the fuel has been cleaned, it will be re-tested. 2. All residents have the potential to be affected. 3. The U.S. FOIA (b) (6) was educated by the Regional Director of Plant operations on the requirement of ensuring that emergency and standby power generator diesel fuel quality was maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems, 2010 edition, Section 8.3.8. 4. Maintenance Director will audit monthly x 3 to ensure that emergency and standby power generator diesel fuel quality was maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems, 2010 edition, Section 8.3.8. 5.The contents of the audit above will be reported by the Maintenance Director or his designee and reviewed at the quarterly QA meeting by the administrator or designee with suggested recommendations made by the committee.	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage	K 921		9/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **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
K 921	Continued From page 12 current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review on 09/05/2024 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to provide an electrical policy for all patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and detailed log of all required tests, test results, safety labels and repairs in accordance	K 921	1. PCREE electrical inspections and tagging has been completed and logged on 9/11/2024 Maintenance/Designee will ensure that the PCREE is completed annually. The PCREE electrical inspections and tagging Policy was completed and added to the annual inspection book on 9/11/2024. Maintenance/Designee will ensure that the PCREE policy is reviewed annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315127	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **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
K 921	Continued From page 13 with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 09/05/2024 between 8:15 AM and 3:30 PM in resident rooms, revealed the following: 1. Room #213 and 217 had electric recliner chairs without inspection stickers. 2. 54 of 54 resident's beds had no inspection stickers. 3. No policies and protocols on PCREE was provided to the surveyor. In an interview at the time, the U.S. FO and U.S. FOIA (b) (confirmed the observation and acknowledged there no no documentation on PCREE. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at Life Safety Code survey exit conference on 09/06/2024 at 3:38 PM. N.J.A.C 8:39-31.2(e) NFPA 99	K 921	2. All residents have the potential to be affected. 3. The U.S. FOIA (b) (6) was educated by the Regional Director of Plant operations on the requirement of ensuring that for all PCREE maintenance is conducted and recorded and a detailed log of all required tests, test results, safety labels and repairs is maintained in accordance with NFPA 99 edition, 2012 edition, Sections 10.3, 10.5.2.1, 10.5.2.1.1, 10.5.2.5, 10.5.3, 10.5.6. 4. Maintenance Director will audit annually to ensure that for all PCREE maintenance is conducted and recorded and a detailed log of all required tests, test results, safety labels and repairs is maintained in accordance with NFPA 99 edition, 2012 edition, Sections 10.3, 10.5.2.1, 10.5.2.1.1, 10.5.2.5, 10.5.3, 10.5.6. 5.The contents of the audit above will be reported by the Maintenance Director or his designee and reviewed at the quarterly QA meeting by the Administrator or designee with suggested recommendations made by the committee.	

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
315127 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/15/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	2381 LAWRENCEVILLE ROAD 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0225	10/13/2024	LSC K0353	10/21/2024	LSC K0363	09/07/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	11/04/2024	LSC K0531	11/08/2024	LSC K0914	10/13/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	10/13/2024	LSC K0921	09/11/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
9/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO