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 _____	**06/02/2023**

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 . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 05/25/2023. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/25/23 and 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. The current occupied beds are 53 of 56. .	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	K 291		6/15/23

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

Electronically Signed | 06/23/2023

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 _____	**06/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **LAWRENCEVILLE, NJ 08648**

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K 291	Continued From page 1 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure emergency lighting was provided at the emergency generator transfer switch in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3. This deficient practice had the potential to affect all 53 residents. Findings include: An observation on 05/25/23 at 11:45 PM revealed emergency lighting was not present at the emergency generator transfer switch located in the electrical room. At the time of the observation, the Maintenance Director confirmed the emergency lighting was not present at the emergency transfer switch. NJAC 8:39-31.2(e) NFPA 99, 110 .	K 291	K291 A light was installed near the transfer switch of the emergency generator. Prior to the light being installed there was a potential to impact all residents in the event of emergency. Maintenance staff were re-educated by the Maintenance Director on the need for lighting at the emergency generator transfer switch. The Maintenance Director / designee will complete audits of the lighting function at the emergency generator weekly for 4 weeks and then quarterly thereafter. Audits will be tracked and trended and reviewed with the quality assurance performance improvement committee. Maintenance Director will add this to his QAPI will be monitored via our CMS Maintenance software programs TELS monthly.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced	K 345		7/14/23

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	315127	A. BUILDING **01** B. WING _____	**06/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHABILITATION HOSPITAL	**2381 LAWRENCEVILLE ROAD** **LAWRENCEVILLE, NJ 08648**

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K 345	Continued From page 2 by: . Based on observation, interview, and record review, the facility failed to ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 53 residents. Findings include: Document review of the facility binder, provided by the Maintenance Director, contained inspection and testing reports for the fire alarm system for the calendar year 2021 and 2022. A review of the facility fire alarm "Inspection and Testing Reports" dated 12/20/22 revealed no reference to a smoke detection sensitivity test. An observation of the facility smoke detectors on 05/25/23 from 11:25 AM to 01:15 PM revealed smoke detectors were located in the corridors at the smoke barriers, 15 feet from the end of the corridors and 30 feet on center, and other concealed areas throughout the building. During an interview on 05/25/23 at 01:40 PM the Maintenance confirmed the smoke sensitivity testing had not been completed on the smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	K345 The fire alarm system was tested by a contracted vendor in accordance with an approved program complying with the requirements of NFPA 72 The missing biannual fire alarm test had the potential to impact all residents in the event of emergency. The contracted vendor will replace any smoke detectors that are noted to be in need of replacement as per the system test. Maintenance staff will be re-educated by the Maintenance Director on the Biannual fire alarm system testing and smoke detector function. The Maintenance Director / designee will complete weekly audits of smoke detector function for 4 weeks and then quarterly thereafter. Audits will be tracked and trended and reviewed with the quality assurance performance improvement committee monthly for 3 months. Sensitivity test was completed on 06-06-2023 any deficient smoke heads have been replaced, the scope of the work was completed on 07-10-2023. Sensitivity of smoke heads will be monitored via our CMS Maintenance software programs TELS monthly.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		6/15/23

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	315127	A. BUILDING **01** B. WING _____	**06/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 761	Continued From page 3 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: . Based on document review, observation and interview, the facility failed to ensure the fire doors were inspected annually in accordance with NFPA 101 Life Safety Code (2012 edition) 7.2.1.15. This deficient practice had the potential to affect all 53 residents. Findings include: Document review of the facility binder provided by the Maintenance Director revealed fire door inspections were not conducted. An observation from 11:30 PM to 1:30 PM confirmed no inspections had been conducted on any of the facility's fire doors and the doors lacked the required inspection tags required to be placed on the door after the inspection. At the time of the observation, the Maintenance Director confirmed the doors were not inspected.	K 761	K761 An audit was completed on all fire doors in accordance with NFPA 101 Life Safety Code The missing audit had the potential to impact all residents in the event of emergency. An audit was completed on all fire doors. Additional audits will be completed at least annually going forward. Maintenance staff were re-educated by the Maintenance Director on fire door inspections and inspection tags. The Maintenance Director / designee will complete audits of fire doors weekly for 4 weeks and then quarterly thereafter. Audits will be tracked and trended and reviewed with the quality assurance performance improvement committee	

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	315127	A. BUILDING **01** B. WING _____	**06/02/2023**

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K 761	Continued From page 4 NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	monthly for 3 months. All fire doors will be inspected in accordance to NFPA 101 Life Safety Code. Tags will checked and monitored monthly via our automated CMS Maintenance software programs TELS.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315127	A. Building 01 - MAIN BUILDING 01 B. Wing	7/21/2023

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 Reg. # NFPA 101 LSC K0291	Correction Completed 06/15/2023	ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 07/14/2023	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 06/15/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/2/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO