STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315338	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWRENCE	**1 BISHOPS DRIVE , LAWRENCEVILLE, New Jersey, 08648**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Complaint #:2735742 Census: 115 Sample Size: 5 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F0000		02/27/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 031103	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWRENCE	**1 BISHOPS DRIVE , LAWRENCEVILLE, New Jersey, 08648**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, Enforcement of Licensure Regulations.	S0000		02/27/2026
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on facility document review on 2/10/26, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 12 of 14 dayshifts. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified 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 Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and	S0560	Corrective action for residents identified as potentially affected Upon notification of the staffing variances identified during the survey review period of January 25, 2026 through February 7, 2026, the Administrator and Director of Nursing immediately conducted a review of staffing schedules, CNA assignment sheets, incident reports, and clinical outcome indicators for residents residing in the facility during the cited period. The review included falls logs, skin integrity reports, grievance logs, and nursing documentation to determine whether any resident experienced an adverse outcome related to the staffing variances. No evidence was identified indicating that any resident experienced a negative clinical outcome attributable to staffing levels during the cited dates. During the cited period, resident care needs continued to be met through staff reassignment, supervisory nursing oversight, and use of available supplemental staffing resources when needed. Immediately upon identification of the concern, the facility implemented corrective measures to ensure CNA staffing levels aligned with New Jersey minimum staffing requirements moving forward. Identification of other residents who may be affected All residents residing in the facility during the cited	02/16/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 031103	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWRENCE	**1 BISHOPS DRIVE , LAWRENCEVILLE, New Jersey, 08648**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0560	Continued from page 1 One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested 2 weeks staffing from 1/25/26 to 2/7/26. The facility was deficient in CNA staffing for residents on 12 of 14 day shifts evidenced as follows: For the 2 weeks of complaint staffing from 1/25/26-2/7/26, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -1/25/26 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs. -1/26/26 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. -1/27/26 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs. -1/28/26 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs. -1/29/26 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs. -1/31/26 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. -2/1/26 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -2/2/26 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -2/4/26 had 11 CNAs for 114 residents on the day shift, required at least 14 CNAs. -2/5/26 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -2/6/26 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -2/7/26 had 12 CNAs for 117 residents on the day shift, required at least 15 CNAs.	S0560	Continued from page 1 timeframe had the potential to be affected by the staffing variances. To ensure no additional areas of concern existed, the Director of Nursing conducted a retrospective review of staffing schedules, call-out reports, and staffing-to-census ratios for the previous thirty days. The review indicated that the staffing variances cited were primarily associated with unanticipated call-outs and staffing fluctuations and did not reflect an ongoing systemic failure of the facility's staffing processes. Systemic measures implemented to prevent recurrence The facility implemented enhanced operational controls to ensure continued compliance with the staffing requirements outlined in N.J.S.A. 30:13-18. A daily census-to-staffing verification process was implemented requiring the Staffing Coordinator and Director of Nursing to review the facility census and staffing grid prior to the start of each shift to ensure that required CNA staffing levels are met. The facility implemented a revised staffing grid tool that automatically calculates the minimum number of CNAs required based on the current resident census to ensure the required day-shift ratio of one CNA to eight residents is consistently maintained. Enhanced call-out management procedures were implemented requiring staff to report absences as early as possible and requiring the Staffing Coordinator and Director of Nursing to initiate immediate replacement coverage through internal staff, voluntary overtime, and staffing pool resources when necessary. The facility also established a staffing escalation protocol which includes administrative review and rapid staffing replacement procedures when unexpected staffing shortages occur. Education was provided to the Staffing Coordinator, Director of Nursing, nurse managers, and nursing leadership regarding New Jersey staffing ratio requirements and the facility's revised staffing oversight process. The facility also strengthened recruitment and	02/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 031103	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWRENCE	**1 BISHOPS DRIVE , LAWRENCEVILLE, New Jersey, 08648**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0560		S0560	Continued from page 2 staffing support strategies including expanded CNA recruitment outreach, local community college C.N.A. training partnerships, and schedule management to maintain adequate staffing coverage. Monitoring to ensure ongoing compliance The Director of Nursing or designee will review the facility census and staffing report daily to verify compliance with required CNA staffing ratios. The Administrator and Director of Nursing will conduct weekly staffing audits for a period of ninety days to ensure the required CNA-to-resident ratios are consistently maintained. Any identified staffing variances will be immediately addressed and corrective action implemented. Staffing compliance will be reviewed as part of the facility's Quality Assurance and Performance Improvement (QAPI) program monthly for three months and quarterly thereafter to ensure sustained compliance.	02/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315338	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWRENCE	**1 BISHOPS DRIVE , LAWRENCEVILLE, New Jersey, 08648**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 03/16/2026 in relation to the 02/10/2026 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 031103	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE REHAB & HCC/THE MEADOWS AT LAWRENCE	**1 BISHOPS DRIVE , LAWRENCEVILLE, New Jersey, 08648**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 03/16/2026 in relation to the 02/10/2026 State of New Jersey Complaint survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities.	S0000		

Office of Primary Care and Health Systems Management

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