STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315113	A. BUILDING _____ B. WING _____	C 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	**112 FRANKLIN CORNER 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 #: NJ173145 Census: 90 Sample Size: 6 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		

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

Electronically Signed | 06/19/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061104	A. BUILDING: _____ B. WING _____	C 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITA	112 FRANKLIN CORNER 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 The facility was not in compliance with the standards in the New Jersey Administrative code, 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 #: NJ173145 Based on interviews and review of facility documents on 6/3/2024, it was determined that the facility failed to ensure staffing ratios were met for 14 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: 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,	S 560	1.The staffing coordinator was educated on the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. The facility will continue to reach out to existing staff to see if they want to pick up overtime shifts and continue to try and staff accordingly. 2.All residents have the ability to be affected by the facility failing to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey.	6/20/24

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

Electronically Signed | 06/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061104	A. BUILDING: _____ B. WING _____	C 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITA	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

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S 560	Continued From page 1 codified as 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 of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing prior to survey from 05/19/2024 to 06/01/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: On 05/19/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. On 05/20/24 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. On 05/21/24 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. On 05/22/24 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. On 05/23/24 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. On 05/24/24 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. On 05/25/24 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. On 05/26/24 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. On 05/27/24 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs.	S 560	3.The facility will continue to post job openings on job sites to promote CNA applications and hirings. The facility has contracted with multiple staffing agencies to assist with our staffing needs. The administrator/ designee will review the daily staffing sheets weekly x 4 then monthly for 3 months and quarterly thereafter. 4. The Administrator/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine frequency of future audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061104	A. BUILDING: _____ B. WING _____	C 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITA	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

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S 560	Continued From page 2 On 05/28/24 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. On 05/29/24 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs. On 05/30/24 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs. On 05/31/24 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. On 06/01/24 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061104 Y1	A. Building B. Wing Y2	6/25/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	112 FRANKLIN CORNER 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 06/20/2024	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
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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 6/3/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			