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 01/16/2025

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

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F 000	INITIAL COMMENTS Complaint #: NJ170741, NJ177257, NJ179885 Survey Date: 1/12/25 to 1/16/25 Census: 95 Sample: 19 + 2 closed records 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		2/4/25

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

Electronically Signed | 02/05/2025

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F 609	Continued From page 1 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: COMPLAINT# NJ00179885 Based on observation, interview and record review, it was determined that the facility failed to submit a report to the New Jersey Department of Health (NJDOH) within the two-hour timeframe for an allegation of [NJ Ex Order 26] made by a resident, (Resident #82). The deficient practice was identified for one (1) of four (4) residents reviewed for [NJ Ex Order 26] investigations and was evidenced by the following: On 1/12/25 at 11:00 AM, the surveyor observed Resident #82 in bed. The surveyor interviewed the resident, and the resident had no concerns. On 1/14/24 at 11:15 AM, the surveyor observed the resident in their room in bed. The surveyor interviewed the resident regarding an incident in [NJ Ex Order 26.4(b)(1)] but the resident had not wanted to speak about any incident regarding staff. The surveyor reviewed the medical record for Resident #82. A review of the Admission Record revealed diagnoses which included but not limited to; [NJ Exec Orde] [redacted] A review of the most recent comprehensive	F 609	How will the corrective action be accomplished for those residents found to be affected by this practice? The facility assessed that the deficient practice was caused by a lack of knowledge by Facility Administration as to the requirements for reporting significant events to the Department of Health. [U.S. FOIA (b) (6)] and Administration was educated by the Chief Nursing Officer in the rules and regulations of reporting significant events to the Department of Health appropriately. Resident #82 already had the reportable event called in, so there was no further action required. How will the Facility identify other residents having the potential to be affected by the same deficient practice? All residents in the facility have the potential to be impacted by the facility failure to report significant events in a timely manner to the Department of Health. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? [U.S. FOIA (b) (6)] and Facility Administration	

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F 609	Continued From page 2 significant change Minimum Data Set (MDS) (an assessment tool used to facilitate the management of care) dated [redacted], reflected that the resident had a brief interview of mental status (BIMS) score of [redacted], indicating the resident had an [redacted] A review of a "Reportable Event Record/Report" provided by the [redacted] that was completed by the [redacted]) indicated an allegation "Resident stated to the 7-3 pm Nurse that [they] was [redacted] across the [redacted] by the [redacted] and that she came in [their] room and shut [their] [redacted])." In addition, the report indicated that the date of the significant event occurred on [redacted] and the time of that event was [redacted]. The report also indicated that the significant event was called in to the NJDOH on [redacted] at 2:59 PM, more than six (6) hours after the time of the event. On 1/14/24 at 10:54 AM, the surveyor interviewed the [redacted] who verified the time of the known allegation from Resident #82 was [redacted] and the NJDOH was notified at 2:59 PM. The [redacted] stated that she was unsure why it took until 2:59 PM to call in the event. The [redacted] added that she was trying to figure out what had happened because when she reached the facility that morning the resident was already taken to the [redacted] for a different reason. She stated it was confusing and took a while to get the information. The [redacted] added that the [redacted]) in question had already left the facility. The [redacted] then stated that an investigation was completed, and the allegation was not substantiated, and that the resident had stated they made a [redacted] after returning from	F 609	was educated by the Chief Nursing Officer on the proper regulation and timeline to report incidents to the Department of Health. The Facility Administrator will review all Reportable Events to ensure events were called in the proper timeframe monthly for 3 months, quarterly thereafter. How will the Facility monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place)? A QAPI was initiated by the Facility Administrator to track and monitor the findings of the Reportable Event audits. This QAPI will be reviewed by the QAPI Team on a monthly basis for three months, at which point the Team will determine the future frequency of these audits.	

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the [redacted] The [redacted] also stated that the [redacted] that was previously here was aware of the statement made by Resident #82 prior to the resident going to the [redacted].

On 1/14/25 at 12:06 PM, the surveyor interviewed the [redacted] who stated that she had been the [redacted] for [redacted] years and had written the nursing progress note dated [redacted] regarding Resident #82 that indicated "Resident is [redacted] with [redacted] called in resident's room by Nurse, Resident stating [they] was [redacted] across [redacted] by the [redacted] and she later came in to [their] room again and shut off [their] [redacted] and slammed the door but the door was too heavy that it couldn't be slamme shut." The [redacted] explained that she was called to the resident's room by the 7 AM to 3 PM nurse and that the [redacted]) had already left the building. The [redacted] added that she had immediately notified her [redacted]

On 1/14/24 at 1:13 PM, the surveyor interviewed [redacted] who stated that he had been employed as the [redacted] for the facility for [redacted] and that there was no employee designated with the title of [redacted] but that he was responsible. [redacted] reviewed the "Resident Rights: Abuse/Neglect Policy" dated as reviewed 11/2023 and acknowledged that the policy had not indicated any requirements for a timeframe as to when to report an allegation of [redacted] to the NJDOH. The [redacted] then stated that any allegation of [redacted] was considered a reportable to the NJDOH and should be done within two (2) hours of the incident. [redacted] acknowledged that

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a statement from a resident that a NJ Exec Order 26.4b1 them would be an allegation of NJ Ex Order 26 and should be reported within two (2) hours to the NJDOH. US FOIA (b) (6) added that he was aware of an incident with Resident #82 that occurred before he started to work at the facility but thought the statement that the resident was NJ Exec Order 26.4b had occurred in the NJ Exec Order 26.4b US FOIA (b) (6) stated that he would have to further review as to why the allegation was not reported within the two (2) hours.

On 1/16/25 at 11:24 AM, the survey team met with US FOIA (b) (6) and U.S. FOIA (b) US FOIA (b) (6) stated that he could not speak for the US FOIA (b) (6)) that was here when Resident #82 had made the allegation but thought that it was possible that because the resident had a care plan that indicated NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 that that was the reason for not calling the NJDOH right away. The U.S. FOIA (b) stated that she had taken the statement seriously and after the first hour she knew she needed to call the NJDOH but got caught up and wanted to hear what had happened from the resident and NJ Exec Order 26. who were both not in the facility. US FOIA (b) (6) stated that they have to err on the side of caution and report. US FOIA (b) (6) and the U.S. FOIA (b) acknowledged that reporting was required within two hours and that an investigation would occur after.

A review of the facility policy for "Incident/Accident Investigating and Reporting" updated 6/2024, provided by US FOIA (b) (6) included "In the event that the incident is found to be reportable based on the DOH reportable guidelines, the necessary information will be reported to the DOH in a timely manner."

A review of the facility policy for "Resident Rights:

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F 609	Continued From page 5 Abuse/Neglect Policy" dated as reviewed 11/2023, provided by [redacted] included the section "Reporting Results of the Investigation: A. Results of all investigations of suspected abuse or neglect will be reported to the Administrator or designee at the immediate conclusion of the investigation. B. Decisions to report alleged incidents of resident to resident abuse will be made on a case by case basis by the administrator." The policy had not indicated when to report to the NJDOH. NJAC 8:39-4.1(a)(5), 9.4(f)	F 609		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of pertinent facility documents, it was determined the facility failed to ensure a.) a physician's order (PO) was in place for a resident who used a [redacted] that helps [redacted] for NJ Exec Order 26.4b1 [redacted] which the resident brought from home, b.) a PO was in place for the proper settings, c.) a PO was in place to maintain the cleanliness of the [redacted] and it's parts in accordance to the manufacturer's instructions.	F 695	How will the corrective action be accomplished for those residents found to be affected by this practice? Upon discovery of the deficient practice for Resident #9: The facility immediately put a Physician Order for the [redacted] and the proper settings, and a Physician Order to properly clean and maintain the [redacted] per manufacturer recommendations. Upon discovery of the deficient practice	2/4/25

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F 695	Continued From page 6 This deficient practice was identified for 1 of 3 residents (Resident #9) reviewed for NJ Exec Order 26.4b1 care; and d.) NJ Exec Order 26.4b1 NJ Ex Order 26.4 were stored properly after use to prevent NJ Ex Order 26.4(b)(1) This was identified for 2 of 3 residents (Resident #9 and #238) that were reviewed for NJ Exec Order 26.4b1 care. This deficient practice was evidenced by the follows: 1. On 1/12/25 at 11:07 AM, the surveyor observed Resident #9 in bed covered with a sheet. The surveyor observed a NJ Exec Order 26.4b1 NJ Exec Orde (a NJ Exec Order 26) lying directly on the bed. The NJ Ex Order 2 was connected to a NJ Ex Order 26.4(b)(1) which the resident identified as a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 which is one of the most common treatments for NJ Exec Order 26.4b1 .) The resident stated the NJ Exec Order 26.4b1 was brought from home and they have used it since admission. The resident stated they NJ Exec Order 26.4b1 and removed the NJ Exec Orde mask. The resident acknowledged the NJ Ex Order 2 was not bagged. The resident stated the staff do not bag the NJ Exec Order 26.4b1 NJ Ex Order 26 In addition, the resident stated their NJ Exec Order 26.4b1 cleaned the NJ Ex Order 2 the night before. The resident further stated that nursing staff stated that a PO was required for them to clean the NJ Exec Order 26.4b and its parts. The surveyor reviewed the electronic medical record (EMR) for Resident #9. A review of Resident #9's Admission Record (an admission summary) reflected the resident had diagnoses which included but were not limited to; NJ Exec Order 26.4b1)	F 695	for Resident #238, the NJ Ex Order 2 was replaced and bagged immediately, and dated properly. The facility determined that these deficient practices are a result of staff not reporting equipment brought in privately by residents, family or friends. An inservice was initiated by the Infection Preventionist Nurse to all CNA's, LPN's and RN's to educate on the rules of reporting unexpected equipment and proper care of NJ Exec Order 26.4b1 . How will the Facility identify other residents having the potential to be affected by the same deficient practice? All residents who utilize a BiPap/ CPAP/ nebulizer machine have the potential to be affected by this deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? All nursing staff were educated by the Infection Preventionist to alert the Director of Nursing if any breathing assisting machines are brought in by residents, resident family or friends. The Director of Nursing or designee will conduct an audit weekly for 4 weeks, and monthly thereafter for 3 months to ensure all appropriate orders are maintained. All nursing staff were educated by the Infection Preventionist on the proper way to store and maintain nebulizer masks. The Infection Preventionist or designee will audit all nebulizer treatments or other oxygen tubing to ensure proper cleaning,	

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F 695	Continued From page 7 NJ Exec Order 26.4b1 [redacted] A review of a quarterly Minimum Data Set, a tool to facilitate the management of care dated NJ Exec Order 26.4b reflected the resident had a Brief Interview for Mental Status score of NJ Exec Order 26.4b1 which reflected the resident had an NJ Exec Orde [redacted]. It also reflected the resident had the diagnoses indicated above. A review of the individualized comprehensive care plan (ICCP) reflected a focus area for NJ Ex Order 26.4 NJ Exec Order 26.4b1 status and NJ Ex Order 26.4(b)(1) related to [redacted] with an initiation date of NJ Exec Order 26 Further review, reflected the resident used a NJ Exec Order 26.4b1 [redacted].) It did not reflect the proper settings, nor care instructions until NJ Exec Order 26.4b which was after surveyor inquiry. A review of the Order Summary Report (OSR) did not reflect a PO for the use of a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 the proper settings, or the instructions to maintain the cleanliness for a NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b and its parts. A review of the electronic Medication Administration Record's (eMAR) and the electronic Treatment Administration Record's (eTAR) for Resident #9 from NJ Exec Order 26.4b1 [redacted], did not reflect any treatments or care for a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 A review of the Vitals Summary NJ Ex Order 26.4(b [redacted] report from NJ Exec Order 26.4b1	F 695	storage and dating of the tubing is done, weekly for 12 weeks. How will the Facility monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place)? A QAPI was initiated by the Director of Nursing and will be reviewed monthly by the QAPI Team for three months to track all residents on BiPap/ CPAP treatments to ensure correct orders are entered and maintained. A QAPI was initiated by the Infection Preventionist to review the findings of the nebulizer mask audits with the QAPI Team monthly for three months. The QAPI team will review both BiPap/ CPAP audits as well as the nebulizer audits after 3 months to determine the frequency of future audits.	

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reflected the resident's NJ Ex Order 26.4(b)(1) was checked on the following dates while the resident's [redacted] for [redacted] was in use:

NJ Exec Order 26.4b1

[redacted]

A review of progress notes from NJ Exec Order 26.4b1 [redacted] did not include any documented evidence that the resident used a [redacted], [redacted] [redacted]

On 1/13/25 at 12:25 PM, the surveyor interviewed the resident in their room. The resident stated the company that provided the NJ Ex Order 26.4(b)(1) for [redacted] sent [redacted] and [redacted] to their family's home.

On 1/14/25 at 11:05 AM, the surveyor interviewed

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the resident's U.S. FOIA (b)(6) [redacted] US FOIA (b) (6) She acknowledged the resident's NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b was used for NJ Exec Order 26.4b1 and was the resident's personal NJ Exec Order 26.4b from home. She stated it was the responsibility of the facility to maintain the NJ Exec Order 26.4b (cleanliness, apparatus changes, etc.) US FOIA (b) (6) could not speak to how often the NJ Exec Order 26.4b or NJ Ex Order 2 needed to be cleaned or the frequency of which parts needed to be changed. She reviewed the POs in the EMR in the presence of the surveyor and acknowledged there were no POs for the NJ Exec Order 26.4b or for its maintenance.

On 1/15/25 at 10:02 AM, US FOIA (b) (6), in the presence of the survey team, stated she was aware of the resident using their personal NJ Exec Order 2 NJ Exec Order 26.4b but she remained unaware of what and how often the family brought in replacement equipment.

On 1/15/25 at 11:07 AM, the surveyor interviewed the resident about the NJ Exec Order 26.4b1 in the presence of a second surveyor. The resident stated it was a NJ Exec Order NJ Exec Order 26.4b1 The resident stated the NJ Exec Order 26.4b was provided and monitored by [name redacted] NJ Exec Order 26.4b1. The resident stated a NJ Exec Order 26.4b1 appointment was conducted every NJ Exec Order 26.4b1. The resident stated the company provided replacement equipment and that the NJ Exec Order 26.4b1 NJ Ex Order 2 needed to be cleaned daily and changed weekly and the NJ Ex Ord needed to be changed weekly as well, which the resident's family took care of. The resident stated the staff stated they were unable to complete these tasks since there were no PO's to do so.

On 1/15/25 at 11:47 AM, the surveyor interviewed

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the U.S. FOIA (b)(6)) in the presence of the survey team. She was unsure if a PO was required to clean a U.S. FOIA (b)(6) NJ Exec Order 26.4b1 or if the staff needed to clean it periodically. She stated the NJ Exec Order 26.4b settings required a PO. The U.S. F stated the NJ Exec Order 26.4b would not work properly if it was not cleaned properly. In addition, she stated the NJ Exec Order 26.4b1 NJ Ex Order 2 should be stored in a bag when it was not in use to avoid contamination which could cause NJ Ex Order 26.4(b)(1) She stated the NJ Exec O was responsible to ensure POs were in place for the NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1 and how to clean and store equipment.

On 1/15/25 at 2:26 PM, the survey team met with administrative team: U.S. FOIA (b)(6) informed the survey team that US FOIA (b) (6) verified the NJ Exec Order 26.4b1 was a NJ Exec Order 2 NJ Exec Order 26.4b and the setting should be NJ Exec Or She and the U.S. FOIA (b) acknowledged that there should have been POs for the NJ Exec Order 26 NJ Exec Order 26.4b use, settings, and it's care according to manufacturer's instructions. She also stated a PO was placed for a NJ Exec Order 26.4b1 consultation. The U.S. FOIA (b)(6) acknowledged that it was the facility's responsibility to clean the NJ Exec Order 26.4b1 The U.S. FOIA (b)(6) stated it was nursing's responsibility to ensure these POs were in place. The administrative team acknowledged this information should have been included in the resident's ICCP.

On 1/15/25 at 2:50 PM in the presence of the survey team, the U.S. FOIA (b)(6) stated the nurse called [name redacted] the NJ Ex Order 26.4(b)(1) group to confirm which type of NJ Exec Order 26.4b NJ Exec Order 26.4b1) the resident had, the settings, and how to care for

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it (the [NJ Exec Order 26.4b1] and to coordinate care going forward with the [NJ Exec Order 26.4b1] group.

On 1/16/25 at 11:24 AM, the survey team met with the[U.S. FOIA (b)(6)]. The [U.S. FOIA (b)] stated that [U.S. FOIA (b)(6)][NJ Ex Order 26.4] should be bagged and kept in the nightstand table drawer when not in use. In addition, she stated nursing obtained the manufacturer's instructions for Resident #9's [NJ Exec Order 2][NJ Exec Order 26.4b1]. The [U.S. FOIA (b)(6] stated if there was an outside piece of equipment in a resident's room, staff should report this to the [U.S. FOIA (b)] to ensure it was addressed properly.

2. On 1/12/25 at 10:00 AM, during initial tour, the surveyor observed Resident # 238 in their bed. The surveyor observed a [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b] with a [NJ Exec Order 26.4b1] [NJ Exec Orde] on the resident's nightstand. The [NJ Ex Order 2] was lying directly on the facility provided newsletter with a facility provided gown resting on top of the [NJ Ex Order 26] The resident stated, "the nurse gives me the [NJ Ex Order 2] with the medicine in it and then comes back and takes the [NJ Ex Order 2] and puts it on the nightstand." The surveyor observed the resident was unable to reach the nightstand.

The surveyor reviewed the EMR for Resident #238.

A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; [NJ Exec Order 26.4b1].

A review of the ICCP revealed: a Focus of [NJ Ex Order 26.4] Date Initiated: [NJ Exec Order 26.4b1]. Interventions:

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F 695	Continued From page 12 monitor for s/sx (signs/symptoms) of [redacted] A review of Resident #238's OSR revealed a PO for NJ Exec Order 26.4b1 [redacted] A review of the eMAR for [redacted] revealed the above medication was administered at [redacted] On 1/15/25 at 10:36 AM the surveyor interviewed the LPN #1, who stated a [redacted] should be rinsed and dried after use and stored in a bag. On 1/15/25 at 10:50 AM, the surveyor interviewed the US FOIA (b) (6) [redacted], who stated a [redacted] should be rinsed and dried after a treatment was given and stored in bag "to be NJ Exec Order 26.4b1 ." On 1/15/25 at 11:19 AM, the surveyor interviewed the [redacted], who stated a [redacted] should be stored in a bag when it was not being used. On 1/15/25 at 11:50 AM, the surveyor interviewed the [redacted], who stated a [redacted] "should be stored in bag, you don't want to leave it all over the place because it is going on [redacted]." On 1/15/25 at 2:25 PM, the surveyor made with the U.S. FOIA (b)(6) [redacted] aware of the above concerns. A review of the facility's policy "Oxygen Tubing and Respiratory Products" revised 6/2024,	F 695		

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F 695	Continued From page 13 revealed Policy: It is the policy and procedure of this facility that all oxygen tubing is of single use for a single resident, clean and properly stored and dated to prevent the transmission of infection ....7. All nebulizer tubing shall be dated and stored in a bag when not in use and replaced every 7 days. NJAC 8:39-29.2(d).	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility documents it was determined that the facility failed to provide care and services in accordance with professional standards by adjusting medication administration times to accommodate a resident's NJ Exec Order 26.4b1 [redacted]) schedule for 1 of 1 resident, Resident #62, reviewed for [redacted] This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and	F 698	How will the corrective action be accomplished for those residents found to be affected by this practice? Prior to the recertification survey, the facility identified and reviewed the orders for Resident #62. All medications scheduled for [redacted] times were adjusted to ensure no medications are scheduled while the resident is out of the facility, and remain appropriately scheduled. The doctor was made informed of this deficient practice and updated on the new medication times. How will the Facility identify other residents having the potential to be affected by the same deficient practice? All residents who have scheduled dialysis	2/4/25

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F 698	Continued From page 14 treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 1/12/2025 at 10:36 AM, during the initial tour, the surveyor observed Resident #62 in their room with the lights off. The resident was in bed and their eyes were closed. On 1/12/2025 during entrance conference with the surveyor, the U.S. FOIA (b)(6) [redacted]) from 11:17 AM to 11:42 AM, the U.S. FOIA (b)(6) verified that the facility did not have an onsite NJ Exec Order 26 unit. The surveyor reviewed the electronic medical record (EMR) for Resident #62. A review of the Admission Record revealed the resident was admitted to the facility with	F 698	are at risk for being affected by this deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? Unit Manager or designee will review and audit all medication times for all residents with scheduled dialysis to ensure medication is being administered at a time which the resident can reasonably take the medications. This review will be monthly for 3 months and quarterly thereafter. How will the Facility monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place)? The Unit Manager will initiate a QAPI and present audit findings monthly for three months to the QAPI team to determine frequency of future audits.	

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diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted]

A review of the admission Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26 revealed the resident had a Brief Interview for Mental Status (BIMS) of NJ Exec Order 26.4b1, indicating the resident's NJ Exec Order 26.4b1 [redacted] Further review of the MDS, revealed the resident was receiving NJ Exec Order 26.4b

A review of the individual comprehensive care plan (ICCP) revealed: Resident needs NJ Exec Order 26.4b1 [redacted]
Intervention: May schedule time of medication to accommodate NJ Exec Order 26.4b schedule.

A review of physician orders (PO) revealed a PO: NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 [redacted] every shift NJ Exec Order 26.4b1 Start date NJ Exec Order 26.4b1

A review of the NJ Ex Order 26.4(b)(1) Medication Administration Records (MAR) revealed on NJ Ex Order 26.4(b)(1 (Tues) code 9 was entered for the administration times of 0900 and 1000; and on NJ Ex Order 26.4(b)(1 (Thurs) a code 1 was entered for the administration times of 0900 and 1000 ;and the

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F 698	Continued From page 16 NJ Ex Order 26.4(b)(1) MAR revealed NJ Ex Order 26.4(Sat and NJ Ex Order 26.4(b)(Tues, a code 9 was entered for the administration times of 0900 and 1000; NJ Ex Order 26.4(Tues, NJ Ex Order 26.4(b Sat, NJ Ex Order 26.4(b)(Thurs, NJ Ex Order 26.4(b)(Sat, NJ Ex Order 26.4(b)(Tues, code 1 was entered for the administration times for 0900 and 1000 for following medications: -NJ Exec Order 26.4b1 [redacted] A review of the MARs chart code revealed a 1= out on med pass with meds and a 9=other/See nurses notes.	F 698		

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F 698	Continued From page 17 A review of the nursing progress notes revealed the following progress notes: NJ Exec Order 26.4b1 Note Text: out on pass-NJ Exec Order 26.4b author LPN#1. NJ Exec Order 26.4b1 Note Text: out on pass NJ Exec Order 26.4b; author LPN#1. -NJ Exec Order 26.4b1 Narrative: Resident was out at NJ Exec Order 26.4b the whole shift, did not return on 7/3 shift. Author NJ Exec Order 26.4b1 -NJ Exec Order 26.4b1 Narrative: Resident is back to facility this morning following their NJ Exec Order 26 treatment earlier. Author LPN #1. NJ Exec Order 26.4b1 Narrative: Resident returned to facility at 1050 following their NJ Exec Order 26 treatment. Author LPN #1. -NJ Exec Order 26.4b1 Narrative: Came back to facility at 1050 after NJ Exec Order 26 treatment. Author LPN #1. -NJ Exec Order 26.4b1 Narrative: Came back to facility at 1050 after NJ Exec Order 26.4b treatment. Author: LPN #1. NJ Exec Order 26.4b1 Narrative: Resident NJ Exec Order 26.4b1. Author: LPN#2 NJ Exec Order 26.4b1 Narrative: Left Facility to NJ Exec Order 26.4b1. Author RN #1. Further review of the progress notes for the	F 698		

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above mentioned dates and medications did not reveal documentation that the physician was notified or that the medications were given.

On 1/15/25 at 10:36 AM, the surveyor interviewed License Practical Nurse (LPN) #1, who stated Resident #62 receives [redacted] on those days. LPN #1 stated "we (the nurses) change medication times according to the [redacted] schedule." He then stated, "if for some reason the resident came back after 10 AM, he would use the code for out on pass and let the doctor know." LPN #1 accessed the eMAR in the presence of the surveyor. He verified a 1= out on pass, and stated the medication was not given because the patient was not there. He stated if a 9 was entered it meant there would be a progress note explaining why the medication was not given. LPN #1 could not show the surveyor a note the physician was notified or that the medications were given for the above mentioned dates.

On 1/15/25 at 10:53 AM, the surveyor interviewed the [redacted] who stated the resident received [redacted]. She further stated if a resident was not in the building, medications should not be schedule at that time. They (the medications) should be scheduled for the time the resident was in the building. The [redacted] stated the doctor should be called after one occurrence to make them aware and to change the time of the medications.

At that time, the [redacted] accessed the electronic

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MAR in the presence of the surveyor. She reviewed Resident #62's [redacted] MARs. She acknowledged the codes on the above mentioned dates and was unable to verify if the physician was notified or that the medications were given for the above mentioned dates. The [redacted] could not speak to why the medications were scheduled for the times when the resident was not in the building on [redacted]. She stated the doctor should have been called and the times changed. She stated it was important for residents to get their medications to keep them therapeutic.

On 1/15/25 at 11:08 AM, the surveyor interviewed the [redacted], who stated residents, who were receiving [redacted], medications should not be timed for when the resident was not in the building. She stated the doctor should definitely be called if the medications were unable to given. Medicines. The [redacted] further stated after one time, the doctor should be called and medication times changed.

At that time, the [redacted] reviewed Resident #62's [redacted] MARs in the presence of the surveyor. She acknowledged the above mention codes for a above mentioned dates and medications. She reviewed the EMR and verified the medications were not given or that the doctor was not called. She was unable to speak to why the medications were not given. The [redacted] stated it was important for residents to receive their medications because of "imbalance, they need to be given on a regular basis."

On 1/15/25 at 2:25 PM, the surveyor made with the [redacted]

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F 698	Continued From page 20 U.S. FOIA (b)(6) of the above concerns. No additional information was provided. A review of the facility policy, "Dialysis Medication" revised 10/2024, revealed: Policy: It is the policy and procedure of this facility to ensure that residents underdoing dialysis receive the appropriated medications to manage their condition. Procedure: 1. The facility may adjust all medications according to the dialysis schedule. 2. Any changes to dialysis schedule, the facility will notify the MD and adjust medication schedule accordingly. NJAC: 8:39-11.2(b), 27.1(a), 29.2(a)(d)	F 698		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a	F 732		2/4/25

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F 732	Continued From page 21 daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. 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 post the nurse staffing report daily. This deficient practice was identified on 1/12/25, and was evidenced by the following: On Sunday, 1/12/25, at 09:00 AM, the surveyor observed the nursing staffing report posted at the front reception desk. The U.S. FOIA (b)(6) was present. The nursing staffing report was dated Friday 1/10/2025, which reflected all shifts for that day. On 1/13/25 at 8:04 AM, the surveyor observed the nursing staffing report posted at the front reception desk had not been updated from 1/10/2025. The U.S. FOIA (b)(6) was present. On 1/13/25 at 10:46 AM, the surveyor observed the nursing staffing report posted at the front	F 732	How will the corrective action be accomplished for those residents found to be affected by this practice? The facility determined that this deficient practice occurred due to a lack of education by the US FOIA (b) (6) as to the regulation to post staffing ratios on a daily basis. The U.S. FOIA (b) (6) was educated by the Administrator that staffing levels must be posted on a daily basis, including weekends. A policy was implemented to ensure weekend staff, namely the receptionists, post the proper daily assignment sheet, as per Federal and State regulation. Staffing Coordinator updated staffing sheet immediately upon discovery of this deficient practice. How will the Facility identify other	

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F 732	Continued From page 22 reception desk had not been updated from 1/10/2025. The U.S. FOIA (b)(6) was present. On 1/14/25 at 8:00 AM, the surveyor observed the nursing staffing report posted at the front reception desk dated 1/13/25 for all shifts. On 1/14/25 at 11:53 AM, the surveyor interviewed the U.S. FOIA (b)(6) staff member, who stated she was the person who posts the staffing at the front desk. The surveyor asked who posts the staffing on the weekends, the U.S. FOIA (b)(6) stated "We don't do it. I post it on Monday." The surveyor made the U.S. FOIA (b)(6) aware of the above observations and that staffing should be posted every day, she stated "gotcha." On 1/14/25 at 12:01 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated staffing was posted every day and the receptionist changed it. The surveyor made the U.S. FOIA (b)(6) aware of the above findings and the interview with the U.S. FOIA (b)(6) A review of the facility's policy "Staffing Ration Reports" reviewed 10/2024, revealed: Policy: It is the policy and procedure of this facility to post the daily staffing ratios. Procedure: 1. The staffing coordinator or designee will post the Staffing Ration Report at the Front desk. NJAC 8:39-41.2 (a)	F 732	residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the facility failure to properly post staffing ratios in a conspicuous location, as per State and Federal regulation. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The U.S. FOIA (b) (6) was educated by the Administrator to properly post staffing requirements as per State and Federal regulation. The Facility Administrator or designee will inspect the front desk area at least weekly to ensure the proper posting of the staffing ratios, for 12 weeks. How will the Facility monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place)? The Administrator will report the findings of this audit to the nursing staffing coordinator if the proper staffing levels are not posted. If this deficient practice continues, the facility may consider disciplinary action to ensure compliance.	

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 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLOVER MEADOWS HEALTHCARE AND REHA	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 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 14 of 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	How will the corrective action be accomplished for those residents found to be affected by this practice? The staffing coordinator was re-educated on the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. The facility will continue to reach out to existing staff and contracted agency staff to see if they can pick up extra and overtime shifts to continue to try and staff accordingly. How will the Facility identify other residents having the potential to be	2/4/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/05/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 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 2/01/21: 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 CNA 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. The survey team requested staffing for the 2 weeks of staffing prior to survey from 12/29/2024 to 01/11/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -12/29/24 had 8 CNAs for 89 residents on the day shift, required at least 11 CNAs. -12/30/24 had 8 CNAs for 89 residents on the day shift, required at least 11 CNAs. -12/31/24 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. -01/01/25 had 8 CNAs for 88 residents on the day shift, required at least 11 CNAs. -01/02/25 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. -01/03/25 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. -01/04/25 had 8 CNAs for 88 residents on the day	S 560	affected by the same deficient practice? All residents have the ability to be affected by the facility failing to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The facility will continue to post job openings on job sites to promote CNA applications and hirings. The facility has contracted with multiple staffing agencies to assist with our staffing needs. How will the Facility monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place)? The administrator/ designee will review the daily staffing sheets weekly x 4 then monthly for 3 months and quarterly thereafter. A QAPI was initiated in which the Administrator 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 01/16/2025

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

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S 560	Continued From page 2	S 560		

shift, required at least 11 CNAs.
-01/05/25 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs.
-01/06/25 had 8 CNAs for 92 residents on the day shift, required at least 11 CNAs.
-01/07/25 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs.
-01/08/25 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs.
-01/09/25 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs.
-01/10/25 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs.
-01/11/25 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs.

On 1/14/25 at 11:53 AM, the surveyor interviewed the Staffing Coordinator/Central Supply (SC/CS) staff member, who stated she was aware of the required CNA staffing ratios for each shift and that the facility was meeting them.

On 1/14/25 at 12:01 PM, the surveyor interviewed the Licensed Nursing Home Administrator, who stated he was aware of the CNA staffing ratios and "we try to meet the ratios."

A review of the facility's policy, "Staffing" reviewed: 8/2024, revealed Policy: It the policy and procedure of this facility to adequately staff the facility in accordance with the NJ state guidelines. Procedure: Daily Staffing: 1. The staffing coordinator along with the Director of Nursing and Administrator will staff the building based on the census and acuity of the building. A. In accordance with the NJ staffing Ratio requirements. i. Day shift-1:8 (CNA to resident), ii. Evening Shift-1:10 (Direct Care Staff to Resident) III. Night Shift-1:14 (direct Care Staff to Resident.

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	061104	A. BUILDING: _____ B. WING _____	C 01/16/2025

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

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S1450	Continued From page 3	S1450		
S1450	8:39-19.7(b) Mandatory Infection Control and Sanitation Storage areas for solid waste containers shall be kept clean. Waste shall be collected from all storage areas regularly to prevent nuisances such as odors, flies, or rodents. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that newly hired employees had received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment, or within thirty days if a Registered Nurse (RN) completed an assessment upon employment, for 2 out of 10 newly hired employee files reviewed. This deficient practice was evidenced by the following: On 01/15/25 at 10:50 AM, the surveyor reviewed the employee health files of ten random newly hired employees since the last Recertification survey date of 10/31/23, which revealed the following: -Employee #1 with a hire date of [redacted] had a completed "Employee Health Examination" and was signed by a Registered Nurse (RN) and a physician on [redacted] A review of the facility provided "Time Card" for Employee #1 revealed their 1st day of work was [redacted], which was 1 day prior to their physical exam.	S1450	How will the corrective action be accomplished for those residents found to be affected by this practice? The Human Resources Manager has been educated to the proper timeline in which new employees must have their physical evaluations completed. A new employee physical was completed immediately for the 2 employees who were out of compliance. How will the Facility identify other residents having the potential to be affected by the same deficient practice? All residents are at risk of being affected by the deficient practice. The Human Resource Manager is now aware and educated as to the requirements and will ensure all new hires receive their new employee physical in a timely manner. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The Human Resources Manager was educated by the Administrator on the	2/4/25

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S1450	Continued From page 4 -Employee #2 with a hire date of [NJ Exec Order 26.4b] had a completed "Employee Health Examination" and was signed by a RN and a physician but it was not dated. The facility provided the employees first day of work as [NJ Exec Order 26.4b] On 01/15/25 at 12:23 PM, the surveyor interviewed the Human Resources Manager (HRM) and the Licensed Nursing Home Administrator (LNHA). The HRM stated the employee fills out the top portion of the "Employee Health Examination" form and then everything else gets done by the RN, usually the Infection Preventionist. She further stated once the RN signs the form, the employee gets seen by the doctor, this is usually done the first day of orientation. The HRM stated the purpose of the physical was to make sure they (the employee) were physically able to the work. The HRM and the LNHA reviewed Employee #1's "Employee Health Examination" form and verified the RN and the physician signed the form on [NJ Exec Order 26.4b]. They also reviewed Employee #2's "Employee Health Examination" form and verified it was not dated. A review of the facility policy "Health Files Policy" updated 7/2024, revealed Policy Statement: It is the policy of this facility to require and maintain an acceptable standard of health and physical condition for employees that is equal to the demands of the jobs. Procedure: 1. All new employees are required to have a physical examination upon employment, by a registered nurse. This physical examination will be reviewed by a licensed physician, advanced practice nurse or physician assistant within 30 days of their first day of employment.	S1450	proper requirements of the timeline of which new hires must have their physicals completed by The Human Resources Manager or designee will audit all new hire physicals, for 90 days. All new Employees will not be allowed to start work until their files are reviewed by the Infection Prevention Nurse to ensure compliance. The Infection Preventionist or the Facility Administrator will also review all new hires physical monthly to ensure compliance with this requirement. How will the Facility monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place)? The Infection Preventionist will present audits and review findings to the Administrator monthly for three months at the QAPI meeting. The QAPI team will determine the future frequency of these audits.	

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
315113 Y1	A. Building B. Wing Y2	3/12/2025 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 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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 02/04/2025	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	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	
1/16/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061104 Y1	A. Building B. Wing Y2	3/12/2025 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 02/04/2025	ID Prefix S1450 Reg. # 8:39-19.7(b) LSC	Correction Completed 02/04/2025	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	
1/16/2025	☐ 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
	315113	A. BUILDING **01** B. WING _____	**01/16/2025**

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

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E 000	Initial Comments Clover Meadow 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 01/13/2025 to 01/15/2025. Clover Meadows Healthcare 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 Occupancies. Clover Meadows Healthcare is a single-story Type III Protected building with a partial basement that houses the facility boiler room, laundry room, electrical closet, folding room, maintenance shop, medical records, and 5 storage rooms. The facility was built in January 1969. The facility is divided into 8 smoke zones. The 50 KW exterior generator powers approximately 100% of the facility: emergency lighting, life support system, heating, hot water, cooling, fire protection, refrigerator, nurse call system, phone system, and sump pumps. The facility has 100 licensed beds with a census of 97.	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321		2/4/25

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

Electronically Signed | 02/06/2025

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
	315113	A. BUILDING 01 B. WING _____	01/16/2025

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K 321	Continued From page 1 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 01/13/2025 in the presence of the U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that hazardous area door was self-closing or automatic closing in accordance with NFPA 101: 2012 Edition, Sections 19.3.2, 19.3.2.1.3 and 19.3.2.1.5. This deficient practice	K 321	How will the corrective action be accomplished for those residents found to be affected by this practice? The door was fitted with a closer which meets the requirements of NFPA 101: 2012 Edition, Sections 19.3.2, 19.3.2.1.3 and 19.3.2.1.5.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315113	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 321	Continued From page 2 had the potential to affect all 95 residents and was evidenced by the following: An observation at 2:29 PM revealed that the kitchen storage room (over 50 sq. ft.) contained combustibles. The door was not self-closing or automatic closing. In an interview at the time of observation, the U.S. FOIA (b) confirmed the observation. The facility's U.S. FOIA (b)(6) was notified of the deficient practice during the Life Safety Code exit conference on 01/15/2025 at 2:45 PM. N.J.A.C 8:39-31.2(e)	K 321	How will the Facility identify other residents having the potential to be affected by the same deficient practice? All residents had the potential to have been affected by this deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The door was fitted with a closer which meets the requirements of NFPA 101: 2012 Edition, Sections 19.3.2, 19.3.2.1.3 and 19.3.2.1.5. This closer will remain in the location to ensure compliance is always met. How will the Facility monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place)? The Facility Administrator and/ or the Maintenance Director will inspect all facility doors at least annually to determine that closers are in compliance with all fire code, including NFPA 101: 2012 Edition, Sections 19.3.2, 19.3.2.1.3 and 19.3.2.1.5. The Facility Director of Maintenance will initiate a QAPI to track compliance with fire doors. This QAPI will be presented to the facility's QAPI committee quarterly for 4 quarters.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101	K 324		2/4/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
K 324	Continued From page 3 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 01/14/2025 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed ensure that 1 of 3 kitchen hood suppression spray nozzles cover was in place to protect the nozzle against grease buildup and clogged in accordance with NFPA 101: 2012 Edition, Section 19.3.2.5.1 and NFPA 96, 17 and 10. This deficient practice had the potential to affect all 95 residents and was evidenced by the following:	K 324	How will the corrective action be accomplished for those residents found to be affected by this practice? The deficient hood suppression spray nozzle was properly fitted with a protective blow off cover. This was done upon discovery of the deficient practice. How will the Facility identify other residents having the potential to be affected by the same deficient practice?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315113	A. BUILDING **01** B. WING _____	**01/16/2025**

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
K 324	Continued From page 4 An observation at 1:15 PM revealed that 1 of 3 kitchen hood suppression system spray nozzles was not provided with protective blow off cover. In an interview at the time of the observation, the U.S. FOIA confirmed the observation. The facility's U.S. FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 01/15/2025 at 2:45 PM. N.J.A.C 8:39-31.2(e) NFPA 17 A, 96	K 324	All residents had the potential to have been affected by this deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The Facility Administrator and/ or the Maintenance Director will inspect the kitchen suppression system nozzles at least quarterly to ensure they all have appropriate blow off covers. How will the Facility monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place)? The Facility Administrator and/ or Maintenance Director will report quarterly to the Director of Facilities the finding of these kitchen suppression system audits. The Facility Director of Maintenance will initiate a QAPI to analyze and track compliance with the kitchen suppression system. This QAPI will be presented to the QAPI Committee monthly for three months.	
K 353 SS=F	Sprinkler System - Maintenance and Testing 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,	K 353		3/7/25

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	315113	A. BUILDING 01 B. WING _____	01/16/2025

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CLOVER MEADOWS HEALTHCARE AND REHABILITATION CENTE	112 FRANKLIN CORNER ROAD LAWRENCEVILLE, NJ 08648

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K 353	Continued From page 5 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 observations and interviews on 01/13/2025 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that fire sprinkler heads were maintained in accordance with NFPA 101:2012 Edition, Section 9.7.5, 9.7.7, 9.7.8, NFPA 25: 2011 Edition, Section 13.6.2.1. This deficient practice had the potential to affect all 97 residents and was evidenced by the following: Observations on 01/13/25 from 8:45 AM to 3:45 PM revealed the following: At 9:15AM, one of 1 fire sprinkler head in Room #100 had paint on the glass bulb. At 12:59 PM, two of 8 fire sprinkler heads in the kitchen were green with a coating of oxidation. At 1:22 PM, one of 5 fire sprinkler head in sprinkler room was green with a coating of oxidation and covered with lint. In an interview, the U.S. FOIA (b) confirmed and	K 353	How will the corrective action be accomplished for those residents found to be affected by this practice? The facility contracted with a fire sprinkler company to replace all deficient sprinkler heads, including the glass bulb on the sprinkler in Room 100, 2 of 8 fire sprinkler heads in the kitchen, and 1 of 5 fire sprinkler heads in the sprinkler room. The deficient sprinkler heads were replaced on Feb 14, 2025 How will the Facility identify other residents having the potential to be affected by the same deficient practice? All residents in the facility had the potential to be affected by an improper sprinkler head. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The facility's contracted fire sprinkler	

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K 353	Continued From page 6 acknowledged the findings. The U.S. FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 01/15/2025 at 2:45 PM. N.J.A.C. 8:39-31.1(c), 31.2(e) NFPA 25	K 353	company will inspect all facility sprinkler heads on a quarterly schedule. Any sprinkler heads requiring service or replacement will be scheduled for service or replacement. The facility Administrator and/ or Maintenance Director will audit the contractor's inspections once the work is complete to ensure compliance is met. How will the Facility monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place)? The Facility Administrator and/ or Director of Facilities will receive a report from the facility's contracted fire sprinkler company reviewing all facility sprinkler heads. Any sprinkler heads found to be oxidized, painted or otherwise in need of service or replacement will have service or replacement done as soon as possible. The Facility Director of Maintenance will initiate a QAPI to track the findings of the contracted fire sprinkler reports to ensure the facility fire sprinklers remains in compliance. This QAPI will be presented to the facility QAPI committee quarterly for 4 quarters.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10	K 355		2/4/25

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K 355	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 01/13/2025 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that Class K portable fire extinguishers was provided with the required instructional placard in accordance with NFPA 101:2012 Edition, Sections 9.7.5, NFPA 10:2010 Edition, Sections 5.5.5.3*. This deficient practice had the potential to affect all 95 residents and was evidenced by the following: An observation at 12:45 PM revealed that the Class K portable fire extinguisher in the kitchen was not provided with an instruction placard that stated that the fire protection system shall be actuated prior to using the portable fire extinguisher. In an interview at the time, the U.S. FOIA (b) [redacted] confirmed the observation. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 01/15/2025 at 2:45 PM. N.J.A.C 8:39-31.1(c), 31.2(e) NFPA 10, 96	K 355	How will the corrective action be accomplished for those residents found to be affected by this practice? An instructional placard for proper use of the K-type fire extinguisher was installed, in accordance with NFPA 101:2012 Edition, Sections 9.7.5, NFPA 10:2010 Edition, Sections 5.5.5.3*. How will the Facility identify other residents having the potential to be affected by the same deficient practice? All residents had the potential to be affected by this deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The instructional card installed by the K-type fire extinguisher, in accordance with NFPA 101:2012 Edition, Sections 9.7.5, NFPA 10:2010 Edition, Sections 5.5.5.3* was installed on a permanent basis. This will ensure the facility remains in compliance with this regulation. How will the Facility monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place)? The Facility Administrator and/ or Maintenance Director will inspect the kitchen, at least monthly, to ensure that all required instructional placards are installed appropriately.	

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K 355	Continued From page 8	K 355	The Facility Director of Maintenance will initiate a QAPI to track and analyze the findings of the kitchen inspection to ensure compliance with the regulations. This QAPI will be presented to the QAPI Committee monthly for 3 months.	
K 521 SS=D	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 interviews between 01/13/2025 and 01/14/2025 in the presence of the U.S. FOIA (b)(6)), it was determined that the facility failed to ensure that resident bathrooms were provided with ventilation in accordance with NFPA 101:2012 Edition, Sections 19.5.2,9.2.1 and NFPA 90 A, Standard for the Installation of Air-Conditioning and Ventilating Systems. This deficient practice had the potential to affect 4 of 95 residents and was evidenced by the following: An observation on 01/13/2025 at 10:01 AM revealed the ventilation in resident room 115 was not functioning when tested by the U.S. FOIA (b) An observation at 11:45 AM revealed the	K 521	How will the corrective action be accomplished for those residents found to be affected by this practice? The facility Maintenance Director installed appropriate ventilation in Room 115 resident bathroom, as well as Room 120 resident bathroom. This ventilation was installed in accordance with NFPA 101:2012 Edition, Sections 19.5.2,9.2.1 and NFPA 90 A, Standard for the Installation of Air-Conditioning and Ventilating Systems. How will the Facility identify other residents having the potential to be affected by the same deficient practice? Being that each room 115 and 120 in the	2/4/25

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K 521	Continued From page 9 ventilation in resident room 120 bathroom was not functioning when tested by the [redacted]. In interview at the time, the [redacted] confirmed the observations. The facility's U.S. FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 01/15/2025 at 2:45 PM. N.J.A.C 8:39-31.2(e) NFPA 90 A	K 521	facility are 2-bedded rooms, the 4 residents residing in those rooms had the potential to be affected by the deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The resident bathrooms which were deficient were fitted with proper ventilation, in accordance with NFPA 101:2012 Edition, Sections 19.5.2,9.2.1 and NFPA 90 A, Standard for the Installation of Air-Conditioning and Ventilating Systems. These ventilation systems were installed on a permanent basis and will be inspected at least monthly by the Facility Director of Maintenance for proper function. How will the Facility monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place)? The Facility Director of Maintenance will report to the Facility Administrator in real time if there is a restroom in the facility whose ventilation system is not functioning to code. These ventilation systems will be scheduled for repair as soon as possible. A QAPI to track and analyze the results of the audits will be initiated by the facility Director of Maintenance. This QAPI will be presented to the QAPI Committee monthly for three months.	

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K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage 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, documentation review and interview from 01/13/2025 to 01/15/2025 in the presence of the[redacted], it was determined that the facility failed to provide the electrical policy for all the patient care related	K 921	How will the corrective action be accomplished for those residents found to be affected by this practice? The Director of Maintenance/ Designee will perform testing on all fixed and	2/4/25

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K 921	Continued From page 11 electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance 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 and 10.5.8. This deficient practice had the potential to affect all 95 residents and was evidenced by the following: Observations on 01/13/2025 from 10:15 AM to 3:10 PM revealed that all fixed and portable patient-care related equipment (PCREE) had no inspection stickers throughout the facility. In an interview at the time, the [redacted] confirmed the findings. Documentation review on 01/15/2025 revealed no policy on patient care related electrical equipment. An interview at that time, the [redacted] confirmed the finding and acknowledged that no policy was provided. The facility's [redacted] was notified of the deficient practice at the Life Safety Code survey exit conference on 01/15/2025 at 2:45 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	portable patient-care related electrical equipment to ensure the proper functioning of their physical integrity, resistance, leakage current, and touch current. Records of any necessary repairs will be properly maintained. Any equipment in need of repair will be tagged “out of service” and scheduled for service. How will the Facility identify other residents having the potential to be affected by the same deficient practice? All residents residing in the facility have the potential to be affected by this deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? The Director of Maintenance or Designee will perform, at a minimum, quarterly testing and audit to all fixed and portable patient-care related electrical equipment. The Director of Maintenance or Designee will report the trends from these observations to the Administrator. Any equipment in need of repair will be tagged “out of service” and scheduled for service. How will the Facility monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place)? The Facility Director of Maintenance will initiate a QAPI to track and analyze trends based on the testing and audit findings.	

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K 921	Continued From page 12	K 921	The Facility Director of Maintenance will present this QAPI to the QAPI Committee monthly for three months.	

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
315113 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/12/2025 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 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 K0321	02/04/2025	LSC K0324	02/04/2025	LSC K0353	03/07/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	02/04/2025	LSC K0521	02/04/2025	LSC K0921	02/04/2025
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?
1/16/2025	☐ YES ☐ NO