STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315338	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Rehab & Hcc/the Meadows at Lawrence	1 Bishops Drive Lawrenceville, NJ 08648

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315338	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Rehab & Hcc/the Meadows at Lawrence	1 Bishops Drive Lawrenceville, NJ 08648

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Complaint #: 2674711 Based on observation, interviews, review of medical records, and review of other pertinent facility documents on 11/25/2025, it was determined that the facility failed to provide adequate supervision to a cognitively impaired resident who wore a wander guard and had a known history of wandering (Resident #2), who eloped from the facility on 11/17/2025. The deficient practice was identified for 1 of 3 residents reviewed for elopement (Resident #2).During the survey a finding that constituted Immediate Jeopardy (IJ) was identified under CFR 483.12(a)(1) F689. The facility failed to: a) provide adequate supervision to prevent a cognitively impaired resident (Resident #2) who was a known elopement risk and wore a wander guard bracelet (a wearable device that triggers alarms and/or locks) from exiting their secure second floor unit when LPN #1 saw Resident #2 on the facility's first floor, b) LPN #1 recognized that Resident #2 belonged on the second floor and took the resident back to the second floor via the facility elevator and returned Resident #2 to the second-floor common sitting area without notifying second floor staff, and c) staff failed to respond appropriately to alarms to prevent the resident from leaving their secure unit, and the facility unsupervised. On the afternoon on 11/17/2025, Resident #2, who resided on the facility's second floor secure unit and wore a wander guard, was found by a Licensed Practical Nurse (LPN #1) on the facility's first-floor asking another resident for directions to a different address. LPN #1 returned Resident #2 to the second floor and left them in the common area. The nurse assigned to Resident #2 was not made aware that the resident has left the facility's second floor secure unit. On 11/17/2025 at approximately 2:30 PM, Resident #2 pushed open a stairwell door on the facility's second-floor secured unit. The resident then pushed open the exit door at the bottom of the stairwell and left the facility. The second-floor Unit Secretary (US #1) silenced the stairwell door alarm without completely checking the area for the resident who caused the alarm to sound. On 11/17/2025 at approximately 3:30 PM or 4:00 PM, LPN #2 could not find Resident #2 while doing his rounds. LPN #2 searched hallways, resident rooms, and bathrooms on the second floor. The search performed by LPN #2 alone lasted approximately 30 minutes. LPN #2 then expanded his search to the facility's first floor, Assisted Living, and Hospital, assisted by LPN #3 and a Certified Nursing Assistant (CNA #1). At approximately 6:00 PM, LPN #2 informed the Director of Nursing (DON) that Resident #2 was missing. It was on 11/17/2025 at approximately 6:00 PM, when Resident #2 had been missing for approximately two and a half hours, that the facility's elopement protocol was enacted. On 11/17/2025 at approximately 10:30 PM, Resident #2 was found by facility staff laying on the ground in a wooded area at the back of facility grounds. The resident was dressed in a shirt and sweater, long pants and socks. The resident called out to facility staff for help and complained of hip pain. The resident was transported to the hospital by ambulance and remained in the hospital until 11/22/2025. Resident #2 returned to the facility with diagnoses including but not limited to compression deformity of the vertebra; urinary retention; and possible pneumonia. The resident was placed on one-to-one (1:1) supervision when they returned to the facility. The facility's failure to a.) provide adequate supervision to prevent a cognitively impaired resident who was at risk for elopement from exiting a secure unit, b.) respond appropriately to wandering and door alarms, and c) enact their elopement protocol timely, placed Resident #2 as well as all residents at risk for elopement and posed a likelihood of serious harm, injury, impairment, or death and resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 11/17/2025 at an unknown time when Resident #2 exited the secure second floor unit and was found on the facility first floor unit. The facility Administration was notified of the IJ on 11/25/2025 at 7:47 PM. The facility submitted an acceptable Removal Plan (RP) on 11/25/2025 at 8:00 PM. The surveyor verified the implementation of the RP during the continuation of the on-site survey on 12/01/2025.The evidence was as follows: A review of the facility policy Wandering and Elopements, with a revision date of March 2019, revealed under Policy Statement, that, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Under Policy Interpretation and Implementation, the facility policy revealed, .3. If a resident is missing, initiate the elopement/missing resident emergency procedure. This section of the facility policy further revealed that staff should determine if the resident is out on pass; initiate a search of the buildings and premises; if the resident is not located, notify facility administration, the resident representative, attending physician, and law enforcement. A review of the facility policy Safety and Supervision of Residents, with a revision date of July 2017, revealed under Systems Approach to Safety, that, Resident supervision is a core component of the system approach to safety. The type and frequency of resident supervision is determined by the individual