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	09/04/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and the 2017 Food Code of the United States (U.S.) Public Health Service and U.S. Food and Drug Administration (FDA), the facility failed to prevent the potential for cross-contamination by allowing the drain from the ice machine to extend down into the floor drain. This had the potential to affect 156 of 165 residents receiving meals from the kitchen.Findings include: Review of the facility's policy titled, Ice Machines and Ice Storage Chests, dated January 2012 (sic) revealed, Policy Statement: Ice machines and ice storage/distribution containers will be used and maintained to assure a sage and sanitary supply of ice. Policy Interpretation and Implementation: 1. Ice-making machines, ice storage chests/containers, and ice can all become contaminated by: .d. improper storage or handling of ice.3. Our facility has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacturer's instructions. Further review of the facility policy reveals it fails to address the need for maintaining an air gap for the machines drain line to prevent the possibility of a backflow into the ice machine. The 2017 Food Code of the U.S. Public Health Service and the FDA included the following: 5-402.11 Backflow Prevention. (A) .a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed. During an observation and interview on 09/01/25 at 12:10 PM, the Dietary Manager (DM), the ice machine drain line was observed to be stuck down into the floor drain. The DM confirmed the drain line to be extended down into the floor drain. Removal of the drain line from the floor drain found the line to be coated with a black substance. When asked, should the drain line be placed inside the floor drain the DM stated, No, it should not be directly in the drain, it should have an 'air gap' to prevent the possibility of backflow entering the ice machine. NJAC 8:39-17.2(g)

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	09/04/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to provide a written notice of transfer and information regarding the bed hold process to the responsible party, and a transfer notice to the receiving hospital for seven residents (Resident (R) 3, R4, R6, R7, R12, R20, and R84) out of the eight residents sampled for hospitalization. This failure had the possibility to negatively impact all residents residing at the facility due to important medical information not being provided to receiving hospital and the resident's responsible party not being aware of the reason for the Resident's transfer or bed hold information.Findings include: 1. Review of R7's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R7 was admitted to the facility on [DATE]. Review of R7's five-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 08/27/25, located under the MDS tab indicated R7 was assessed to have a Brief Interview for Mental Status (BIMS) score of 11 out of 15 indicating R7 was moderately impaired. Review of R7's form titled, New Jersey Universal Transfer Form dated 08/13/25 and provided by the facility revealed the facility provided medical information to the receiving hospital regarding R7 in preparation of R7's transfer. Review of R7's EMR indicated there was not a notice of transfer or bed hold notice that was provided to R7's responsible party. Also, the information regarding the appeals process could not be located and was not provided to the responsible party. 2. Review of R20's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R20 was admitted to the facility on [DATE]. Review of R20's five-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 07/24/25, located under the MDS tab indicated R20 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating R20 was moderately cognitively impaired. Review of R20's EMR indicated there was not a notice of transfer or bed hold notice provided to R20's responsible party. Also, the information regarding the appeals process could not be located and was not provided to the responsible party. During the EMR review a copy of the transfer form that was sent to the hospital with R7 was not located. 3. Review of R3's "admission Record in the Electronic Medical Record (EMR) under the "Resident tab indicated he was initially admitted to the facility on [DATE] with a diagnosis of acute respiratory failure. Review of R3's quarterly "Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/20/25 and located in the resident's EMR under the MDS tab indicated that the resident had been re-admitted on [DATE] and did not include most recent hospitalization of 07/28/25 from a short-term hospital. Review of R3's "Progress Note dated 07/28/25 located in under the "Progress Notes tab stated, "Received patient in bed, patient was in distress.patient was transferred to Capital Health. Review of R3's "SNF/NF [Skilled Nursing Facility/Nursing Facility] to Hospital Transfer Form dated 07/28/25 and provided by the facility indicated that R3 was sent to the hospital for shortness of breath. Review of R3's "Notice of Intent to Transfer/Discharge Resident with less than 30-day notice (New Jersey) - V 5 dated 07/28/25 and provided by the facility indicated that R3 was transferred to an acute care hospital ".The discharge or transfer is necessary for the resident's welfare, and the facility cannot meet the resident's needs. During an interview on 09/03/25 at 8:52 AM, Responsible Party (RP) 3 stated she was aware that R3 was sent to the hospital on [DATE] due to chest congestion, but she did not receive any documents or any information on bed holds or transfers. 4. Review of R12's "admission Record in the EMR under the "Resident tab indicated he was initially admitted to the facility on [DATE] with a diagnosis of bloodstream infection. Review of R12's Entry "MDS with an ARD of 08/25/25 was re-admitted from a short-term general hospital. Review of R12's medical records located in the EMR revealed no "SNF/NF to Hospital Transfer Form or "Notice of Intent to Transfer/Discharge Resident with less than 30 day notice (New Jersey) - V 5. Review of R12's Census tab in the EMR revealed he was admitted to the hospital on [DATE] and returned to the facility on [DATE]. Review of R12's (continued on next page)

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	09/04/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	''Progress Notes located in the EMR under the ''Progress Notes tab and dated 08/20/25 stated ''.Resident will be transfer to [NAME] Medicine of Plainsboro ER [Emergency Room] for Purulent drainage from Abdominal Surgical Wound. 5. Review of R4's admission Record located in the resident's EMR under the Profile tab revealed the resident was admitted to the facility on [DATE]. Review of R4's discharge MDS with an ARD 06/28/25 located in the resident EMR under the MDS tab revealed the resident was an unplanned discharged to an acute care setting with return anticipated. Review of R4's Nurses Note, dated 06/28/25 and located in the resident's EMR under the Progress Notes tab revealed the resident was admitted to the hospital with diagnosis of acute kidney injury, heart failure, and elevated potassium level. Review of R4's Hospital Transfer Form, dated 06/27/25 and located in the resident's EMR under the Evaluations tab revealed information from the resident's transfer from the hospital to the nursing facility and not the 'resident's transfer from the facility to the hospital. There was no documentation on the transfer form or in the nurses' notes discussion of the bed hold policy. During an interview on 09/03/25 at 5:15 PM, the Social Services Director (SSD) stated that she fills out the Intent to Transfer in the EMR and she does not send it to anyone. She was under the impression that the facility provided the bed hold policy upon admission, and she was not sure if anyone sends anything to the Responsible Party upon transfer to the hospital. 6. Review of R6's admission Record located in the resident's EMR tab titled Profile revealed the resident was admitted to the facility on [DATE] and most recently readmitted to the facility on [DATE]. with diagnoses that included cerebral infarct and above the knee amputation. Review of R6's discharge MDS with an ARD 06/24/25 and located in the resident's EMR under the MDS tab revealed the resident was discharged to an acute care facility with return to the facility anticipated. Review R6's Nursing Note dated 06/24/25 and located in the resident's EMR under the Progress Notes tab documented the resident with blackish discoloration of the left foot with foul smelling wounds on the great and second toes. The physician and R13's spouse were notified of the findings. The spouse agreed to transfer to acute care facility for evaluations and treatment. Also, the progress notes did not indicate if a bed hold was discussed with the spouse. Review of R6's Hospital Transfer Form, dated 06/24/25 and located in the resident's EMR under the Evaluations tab failed to reveal if the required documents were sent with the resident when transferred to the hospital. Interview on 09/03/25 at 12:45PM with Family Member (F) 1 revealed she was present when the facility made her aware that R6 needed to be transferred to the acute care facility for evaluation and treatment. F1 also stated the facility did not provide her with copies of the documents sent with the resident to the acute care facility. F1 further stated the nursing staff did not discuss the facility bed hold policy with her prior to the resident's transfer. 7. Review of R84's admission Record located in the resident's EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Review of R84's entry MDS with and ARD 06/04/25 and located in the resident's EMR under the MDS tab revealed the resident was readmitted to the facility from acute care hospital. Review of R84's Nurses Note dated 05/24/25 and located in the resident's EMR under the Progress Notes tab revealed the resident was found unresponsive on the floor. The resident was noted to have bump to left side of the forehead, skin tear to left facial check, and left elbow. The nurse's note documented the facility physician and family were notified. However, there was no documentation of the bed policy being discussed with the resident and/or the resident's family. Review of R84's Hospital Transfer Form dated 05/24/25 and located in the resident's EMR under the Evaluation tab revealed the resident's responsible party was notified of the resident's transfer but did not receive anything in writing about the transfer. Also, there was no documentation of the Bed Hold Policy that was discussed with the responsible party. Interview with Registered Nurse (RN) 2 on 09/03/25 at 10:03 AM revealed once it was identified a resident needed to be transferred to an acute care facility for evaluation, the family was notified. RN2 stated the paperwork sent with the resident included face sheet, physician orders, the resident's medication administration record, lab and x-ray report, and their progress notes. RN2 stated the nurses were more focused on the clinical aspect of (continued on next page)

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	09/04/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transferring the resident to acute care setting. RN2 also stated the bed hold policy was signed upon admission to the facility but the nurses do not review the bed hold policy with the residents or the residents' responsible party prior to transfer to an acute care setting. RN2 also stated a copy of the documents sent with the resident during transfer was not given to the residents' responsible party. RN2 further stated she was not aware if this had ever been done or who was responsible for getting this information to the resident's responsible party. During an interview on 09/04/25 at 12:15 PM with the Administrator, stated she was not aware that transfer information (medical information) needed to be provided to the receiving hospital upon transfer. Also, the Administrator was not aware of the reason for the residents' transfer and bed hold information was not being provided to responsible party. The Administrator stated a phone call was always made by nursing to the Responsible Party/family member regarding the resident's transfer. During an interview on 09/04/25 at 4:10 PM, Registered Nurse (RN) 1 and RN3 stated when they sent a resident out to the hospital they filled out a Universal Transfer Form that goes with the resident's packet which would include the face sheet/admission record, labs, orders, and advance directive information. Both nurses confirmed that when a resident was being sent out to the hospital, a phone call would be placed to the responsible party (RP), but they did not provide any transfer/discharge or bed hold notifications to the RP. Review of the facility's policy titled, Transfer, Emergency Acute Care dated 03/2025 indicated, Policy Statement Residents transferred to an acute care setting for emergency treatment are provided with a notice of transfer and are permitted to return to the facility. Policy Interpretation and Implementation.2. When a resident is temporarily transferred to an acute care facility, a notice of transfer is provided to the resident and resident representative as soon as practicable before the transfer.7. The facility bed-hold and return policy ensures residents may return to their previous room within the bed hold period following a hospitalization.regardless of payment choice. 8. Residents who seek to return to the facility after the expiration of the bed-hold period.are allowed to return to their previous room if available or immediately to the first available bed. Review of the facility's undated document titled Hospital Transfer Documentation Checklist directed staff as follows: Please send the following to the hospital at the time of transfer. Transfer form/face sheet with demographics.Current medication list (with last administered doses) to Recent physician orders. Advance directives/DNR status/Code status/POLST. Bed Hold Policy notice. Latest vital signs. Current care plan Summary.Nursing progress notes. MAR (Medication Administration Record) / TAR (Treatment Administration Record) .Allergies list.Any recent (within the last 30 days) labs or diagnostic studies. NJAC 8:39-4.1(a)32,33NJAC 8:39-5.3(b)

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	09/04/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the presence of a pressure ulcer for one of three residents reviewed for pressure ulcers (Resident (R) 169) out of 37 sampled residents. This failure placed the resident at risk for unmet care needs.Findings include:Review of the RAI Manual dated 10/01/19 indicated, . information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment.Review of R169's admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included cerebral infarct with hemiplegia and hemiparesis, and cutaneous abscess.Review of R169's five-day Medicare MDS with an Assessment Reference Date (ARD) of 10/08/24 and located in the resident's EMR under the MDS tab revealed the resident was admitted to the facility with one stage III pressure ulcer.Review of R169's Wound Assessment Report, dated 10/25/24 and located in the resident's EMR under the Miscellaneous tab revealed the resident had a stage III pressure ulcer to the sacrum measuring four centimeters by three centimeters.Review of R169's quarterly MDS with and ARD of 10/30/24 and located in the resident's EMR under the MDS tab revealed the resident was not coded as having any pressure ulcers.During an interview on 09/04/25 at 3:48 PM, the MDS Coordinator (MDSC) reviewed R169's wound assessment reports and the quarterly MDS with an ARD of 10/30/24. The MDSC acknowledged the quarterly MDS did not reflect the resident's stage III pressure ulcer. NJAC 8:39-33.2(d)

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	09/04/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of facility's policy, the facility failed to ensure care plans were developed to include hospice services for one resident reviewed for hospice services (Resident (R) 13) out of 37 sampled residents. This failure had the potential for R13 not to receive adequate hospice nursing services.Findings include:Review of the facility's policy titled Comprehensive Care Plan Development, revised March 2022 reads in part The interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition.Review of the facility's policy titled Hospice Program, revised July 2017 read in part .It is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice re presentative, and ensure that the level of care provided is appropriately based on the individual resident's needs.Review of R13's admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia, senile degeneration of the brain, diabetes mellitus type II, and gastroesophageal reflux.Review of R13's Physicians Order dated 06/17/25 and located in the resident's EMR under the Orders tab revealed Hospice to evaluate and treat.Review of R13's Hospice Care Business Office Notification Form, dated 06/18/25 and located in the resident's EMR under the Miscellaneous tab revealed R13 was accepted for hospice services.Review of R13's significant change in status Minimum Data Set (MDS) with an Assessment Reference Date of 06/23/25 and located in the resident's EMR under the MDS tab revealed the resident was placed on hospice services.Review of 13's Care Plan revised 06/19/25 and located in the resident's EMR under the Care Plan tab revealed the resident was receiving hospice services due to terminal diagnosis; however, the care plan interventions only included services provided by social services but did not reflect the services provided by nursing services.An interview on 09/03/25 at 3:10 PM with Registered Nurse (RN) 2 revealed the resident received weekly visits from the hospice and daily visits from the hospice certified nursing assistant. RN2 acknowledged the resident's care only addressed the services provided by the hospice social services and nothing from the hospice nursing services. RN2 stated the resident's care plan should have included the hospice nursing services. NJAC 8:39-11.2(e) thru (i)NJAC 8:39-27.1(a)

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	09/04/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure that quality of care/treatment was provided to one resident (Resident (R) 75) of eight residents reviewed for weights. Specifically, the facility failed to follow physician orders related to daily weights for fluid retention monitoring/congestive heart failure. This failure increased the risk of worsening heart failure which could lead to fluid retention, increased swelling/edema, and shortness of breath. Findings include: Review of the facility's policy titled Weight Assessment and Intervention, revised 03/2022 and .Residents are weighed upon admission and at intervals established by the interdisciplinary team. Review of R75's admission Record, located in the Electronic Medical Record (EMR) under the Profile tab revealed she was admitted to the facility on [DATE] with a primary diagnosis of multiple sclerosis and comorbidities including congestive heart failure (CHF) (per physician orders). Review of R75's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/01/25 included a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating that the resident was cognitively intact. Additionally, the assessment included daily diuretic usage with no weight gain/loss noted. Review of R75's Care Plan Report, located in the EMR under the Care Plan tab included R75 being on diuretic therapy related to heart failure (05/31/24) with the need for obtaining weights at ordered intervals (05/31/24). Review of R75's Order Summary Report, located in the EMR under the Orders tab included an order for daily weight in the morning for CHF as of 01/29/25. During an interview on 09/01/25 at 11:45 AM, R75 stated that she had persistent left leg swelling and was on a diuretic for heart failure. R75 stated she had not been weighed in 2 weeks and was supposed to be weighed daily. Staff told her they could not find the part to weigh her on the mechanical lift scale. During an interview on 09/03/25 at 10:45 AM, Licensed Practical Nurse (LPN) 4 stated that the Certified Nursing Assistants (CNAs) weighed the residents and then recorded the weights on the weight log, and then the nurses then enter the weights in the EMR. During an interview on 09/03/25 at 11:45 AM, CNA3 stated the CNAs weighed the residents throughout the day and either write it on the paper and if not there, then the nurses enter the information into the EMR. If the weight was not documented, then it was not done. During an interview on 09/03/25 at 11:55 AM, R75 stated she was weighed today, they told her they found the mechanical weight device, but for August they did not do daily weights. During an interview on 09/03/25 at 3:45 PM, LPN5 stated the CNAs obtained the weights and then write them in the weight binder. LPN5 demonstrated that the mechanical lifts were attached to the ceiling and if the aides did not know how to use it or if it got stuck and they are unable to use it, then the resident would not be weighed that day. Also, if the 11:00 PM to 7:00 AM shift was unable to weigh the resident, which did happen on occasion, then the resident would not be weighed because they want to weigh the resident before they ate or drank anything. LPN5 confirmed R75's weights on file and confirmed that if the weights were not in the paper binder or in EMR then the weight was not obtained. If no one was available that knew how to use the machine, then no one weighed the resident. During an interview on 09/03/25 at 3:53 PM, CNA1 stated if a new aide came and did not know how to use it (mechanical lift scale) then they may not weigh R75; however, they should have asked someone that was familiar with the machine but that did not always happen. During an interview on 09/04/25 at 6:09 PM, the Director of Nurses (DON) stated weights were done on the 11:00 AM-7:00 PM shift and that she would check with the unit manager to see if she had any additional weights for R75. The DON confirmed R75 was supposed to be weighed daily before 7:00 AM and her expectation was that the resident would have been weighed daily per the resident's physician orders. NJAC 8:39-27.1

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	09/04/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of facility policy, the facility failed to ensure medications were properly stored for one of 37 sampled residents (Resident (R) 162) when Flonase (an over the counter nasal spray medication used to treat allergies) was observed at the resident's bedside. Additionally, the facility failed to ensure one of two treatment carts was locked. These failures had the potential to result in residents being subject to unsafe or ineffective treatment or adverse effects leading to more serious illnesses and could permit unauthorized access to residents' medications and treatment supplies.Findings include:Review of facility's undated policy titled Administering Medications, directs staff as follows .Residents may self -administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision -making capacity to do so safely. Review of the facility's undated policy titled Medication Labeling and Storage directs staff .The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. 1. Review of R162's admission Record, located in the EMR under the Profile tab revealed R162 was admitted to the facility on [DATE] with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction. Review of R162's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/24/25 included a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating that the resident was cognitively intact. Review of R162's Care Plan located in the EMR under the Care Plan tab did not indicate that he was a candidate for self-administration of medications.Review of R162's Assessments, located in the EMR under the Assessments tab did not include a Self-Administration of Medications assessment.Review of R162's Order Summary Report, located in the EMR under the Orders tab included an order dated 06/28/25 of fluticasone propionate (Flonase) nasal suspension 50 micrograms (mcg), administer two sprays in both nostrils once daily for allergy. During an observation and interview on 09/04/25 at 3:20 PM, R162 was sitting up in his high back wheelchair and Registered Nurse (RN) 5 was administering the resident medications. Continued observation revealed R162 had a container of Flonase nasal spray on his dresser in his room. RN5 stated the medication should be in the locked medication cabinet on the wall, not on the dresser. RN5 then took the medication and locked it away. RN5 confirmed that the resident was not a candidate for self-administration of medication due to physical disability.During an interview on 09/04/25 at 7:04 PM, the Director of Nurses (DON) confirmed that no medications should have been left at the bedside unless the resident had been approved for self-administration of medications. The DON confirmed that R162 was not a candidate for self-administration of medications.2. Observation on 09/03/25 at 9:10 AM revealed the treatment cart on the [NAME] Unit was left unlocked while the Licensed Practical Nurse (LPN) 3 and the Wound Care Consultant were in a resident's room. The treatment cart was out of line of sight of LPN3. The treatment care supplies contained wound cleanser, several types of wound care supplies, hydrogen peroxide, alcohol wipes, zinc oxide, etc. Interview on 09/03/25 at 9:30 AM with LPN3 revealed she could not lock the treatment cart because only the medication nurse had the keys to the treatment cart. The LPN started since the treatment cart contained the supplies above, the cart should have been locked when she was away from the cart. Interview on 09/04/25 at 4:27 PM with the Director of Nursing (DON) revealed she was aware of the incident with LPN3 and the treatment cart. The DON stated she had the keys to all medication and treatment carts and there was no reason why LPN3 could not have come to her to sign out the keys for the treatment cart. NJAC 8:39-29.4(h)

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	09/04/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure one of five residents (Resident (R) 11) reviewed for immunizations was offered the influenza immunization. Specifically, the facility failed to offer R11 the influenza immunization in 2024. This failure increased the risk of R11 contracting the influenza virus.Findings include: Review of the facility's policy titled, Influenza Vaccine, revised 03/2022 stated, All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza.Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized. Review of R11's admission Record, located in the Electronic Medical Record (EMR) under the Profile tab indicated that he was originally admitted to the facility on [DATE] with a primary diagnosis of pleural effusion. Review of R11's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/25/25 indicated that a Brief Interview for Mental Status (BIMS) was unable to be completed due to severe cognitive deficits. Review of R11's Physician Orders, located in the EMR under the Orders tab did not include any immunization orders. Review of R11's Care Plan located in the EMR under the Care Plan tab did not include any immunization status. Review of R11's Immunizations, located in the EMR under the Immunizations tab revealed that R11 had not received the influenza immunization since 10/02/23. No declination or education was available to indicate he had been offered the vaccine in 2024. During an interview on 09/04/25 at 5:41 PM, the Infection Preventionist (IP) confirmed R11's medical records did not include any indication that he had been offered the influenza immunization in 2024 but should have been. NJAC 8:39-19.4(h)

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	09/04/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure three of five residents (Resident (R) 11, R33, and R141) were offered the COVID-19 vaccine boosters. This failure increased the risk of contracting COVID-19. Findings include: Review of the facility's policy titled, COVID-19 Vaccination, revised 09/14/23 stated, Staff members and residents who meet COVID-19 vaccine eligibility criteria will be offered vaccination in accordance with recommendations from the Center for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). Review of CDC recommendations for 2024-2025 COVID-19 vaccinations located at cdc.gov/covid/vaccines/stay-up-to-date.html as of May 29, 2025, the schedule incorporates the HHS [Health and Human Services] directive regarding COVID-19 vaccine recommendations.for adults19-26, 27-29, and 50-64 was to receive one or more doses of 2024-2025 vaccine and for adults older than [AGE] years of age should receive two or more doses of 2024-2025 vaccine. 1. Review of R11's admission Record, located in the Electronic Medical Record (EMR) under the Profile tab indicated that he was originally admitted to the facility on [DATE] with a primary diagnosis of pleural effusion. R11 was an [AGE] year-old male. Review of R11's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/25/25 and located in the resident's EMR under the MDS tab indicated that a Brief Interview for Mental Status (BIMS) was unable to be completed due to severe cognitive deficits. Additionally, the assessment indicated that the COVID-19 immunization was not up to date. Review of R11's Physician Orders, located in the EMR under the Orders tab did not include any immunization orders. Review of R11's Care Plan located in the EMR under the Care Plan tab did not include any immunization status. Review of R11's Immunizations located in the EMR under the Immunizations tab revealed that R11 had not received any COVID-19 immunizations since 04/13/21. No declination or education was available to indicate he had been offered the vaccine in 2024 or 2025. During an interview on 09/04/25 at 5:41 PM, the IP confirmed R11's medical records did not include any indication that he had been offered the COVID-19 immunization in 2024 or 2025 but should have been. 2. Review of R33's admission Record located in the EMR under the Profile tab indicated that she was originally admitted to the facility on [DATE] with a primary diagnosis of diabetes mellitus. R33 was an [AGE] year-old female. Review of R33's annual MDS with an ARD of 08/18/25 and located in the resident's EMR under the MDS tab indicated that she had a BIMS score of 12 out of 15 indicating that she was moderately cognitively impaired. Additionally, the assessment indicated that the COVID-19 immunization was not up to date. During an interview on 09/01/25 at 11:50 AM, R33 stated her only concern was that she would receive the COVID-19 vaccine this year. R33 stated the facility refused to administer her the COVID-19 vaccine last year with no reason given. Review of R33's Physician Orders located in the EMR under the Orders tab included an order dated 12/13/23 for COVID-19 vaccine as indicated by CDC Guidelines. Review of R33's Care Plan located in the EMR under the Care Plan tab did not include any immunization status. Review of R33's Immunizations located in the EMR under the Immunizations tab revealed that R33 had received COVID-19 immunizations on 03/03/21, 09/27/22, 12/13/23, and 05/07/25. No declination or education was available to indicate he had been offered the vaccine in 2024. Review of R33's COVID-19 Immunization Informed Consent- Resident form dated 05/07/25, located in the EMR under the Misc [miscellaneous] tab indicated that she was educated on COVID-19 immunizations and accepted to receive the immunization. During an interview on 09/03/25 at 2:35 PM, the Infection Preventionist (IP) stated based on CDC guidelines, R33 could have received a dose in 2024, and she was not sure why this was not offered and given by the previous IP. 3. Review of R141's admission Record located in the EMR under the Profile tab indicated that she was originally admitted to the (continued on next page)

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	09/04/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on [DATE] with a primary diagnosis of dementia. R141 was a [AGE] year-old female. Review of R141's quarterly MDS with an ARD of 08/24/25 and located in the resident's EMR under the MDS tab indicated that a BIMS was unable to be completed due to severe cognitive deficits. Additionally, the assessment indicated that the COVID-19 immunization was up to date. Review of R141's Physician Orders located in the EMR under the Orders tab included an order dated 11/09/23 for COVID-19 vaccine as indicated by CDC Guidelines. Review of R141's Care Plan located in the EMR under the Care Plan tab indicated that she had COVID-19 on 08/26/25. Review of R141's Immunizations located in the EMR under the Immunizations tab revealed that R141's most recent COVID-19 immunization was on 11/09/23. Review of R141's COVID-19 Immunization Informed Consent- Resident form dated 09/24/24, located in the EMR under the Misc [miscellaneous] tab indicated that she was educated on COVID-19 immunizations and accepted to receive the immunization but did not receive it. Review of R141's Progress Notes located in the EMR under the Progress Notes tab dated 01/22/25 stated, per MD [medical doctor] - hold covid vaccine administration until patient is recovered from flu. During an interview on 09/04/25 at 1:58 PM, the IP confirmed R141 was not offered the COVID-19 immunization after recovering from influenza on 1/22/25. The IP also confirmed R141 should have received the COVID-19 immunization in 2024 and was not sure why this did not occur. NJAC 8:39-5.1(a)