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	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clover Meadows Healthcare and Rehabilitation Cente	112 Franklin Corner Road Lawrenceville, NJ 08648

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint # 2581082Based on observation, interview, medical record review and review of other pertinent facility documentation it was determined that the facility failed to update and revise a resident's Comprehensive Interdisciplinary Care Plan (CICP) after facility identification of a skin condition. This deficient practice was identified for 1 of 3 residents (Resident #1) and was evidenced by the following:A review of the resident admission Record (admission summary) indicated that Resident #1 was admitted to the facility with the diagnoses which included but was not limited to dementia, depression, and malignant neoplasm of the breast.A review of the annual Minimum Date Set (MDS-an assessment the facilitates a resident's care) dated 9/27/25, indicated that Resident #1 had severe cognitive deficits and was dependent on staff for activities of daily living. The MDS also reflected that the resident was at risk for the development of pressure ulcers. The MDS indicated that the resident had interventions in place such as a pressure reducing device for the wheelchair and bed, with application of ointments and medication to the skin.On 10/23/25 at 9:30 AM, during initial tour, the surveyor conducted incontinent checks with the Licensed Practical Nurse Unit Manager (LPN/UM). The surveyor observed Resident #1 lying in bed. The resident was not interviewed due to poor cognition. The resident gave the LPN/UM permission to check the incontinent brief to ensure cleanliness and dryness. The surveyor observed that the resident was clean and dry, and bed linen was clean. The surveyor observed a dressing applied to Resident #1's right buttocks, dated 10/22/25. The LPN/UM removed the dressing, and the surveyor observed a small fluid filled blister. On 10/23/25 at 9:45 AM, the surveyor reviewed Resident #1's electronic medical record which revealed the following:A review of the Progress Note (PN) dated 10/20/25 at 23:15 hours (11:15 PM), indicated that a weekly skin and foot evaluation had been completed and documented that the resident's skin was intact and free from abnormal findings.A review of the PN dated 10/21/25 at 12: 20 PM, indicated that a blister was identified on the right buttocks during morning care. The physician was notified, and a treatment order was received and implemented. The note also indicated that the family was informed.The facility Injury Report (IR) dated 10/21/25 at 12:05 PM, indicated that during morning care, a Certified Nursing Assistant reported to the nurse that Resident #1 had a blister on the right buttocks. The blister measured 1 cm x 0.5cm x 0 cm. Due to confusion, Resident #1 was unable to explain how the blister could have occurred. The IR reflected that a treatment was performed to the area and that the physician and Responsible Party (RP) were notified. The IR revealed that the interventions that were instituted after identified of wound were, weekly wound rounds with the wound care consultant, offlaid bilateral heels and initiate wound treatment.The physician Order Audit Report reflected a physician order dated 10/22/25 to apply bacitracin to the right buttocks and cover with a bordered foam dressing everyday shift for 5 days.A review of Resident #1's CICP dated 9/19/24, indicated that Resident #1 had a potential for skin breakdown, not an actual skin breakdown. The goal stated: [Resident #1] skin will remain intact, and interventions included the following: Apply Skin barrier cream per facility protocol and as needed, assist/remind to reposition frequently and monitoring the skin weekly and PRN (as needed) per protocol. On 10/23/25 at 10:10 AM, the surveyor interviewed the Registered Nurse (RN) who stated that Resident #1 required complete care with all aspects of activities of daily living and received preventive protective skin care. The RN confirmed that the resident had a blister on the right buttocks which required a treatment. The RN further stated that once that blister was identified as a new skin impairment, that its was the LPN/UM responsibility to update that CICP with new preventive protective skin treatment interventions.On 10/23/25 at 10:20 AM, the surveyor interviewed the LPN/UM who stated that when a blister was identified, staff usually monitor it to determine if it developed into a wound. The LPN/UM stated that a blister was not considered a wound, and therefore, there was no need to update the CICP at that time.On 10/23/25 at 10:30 AM, the surveyor interviewed the Director of Nursing (DON) who reviewed Resident #1's CICP and stated that once the blister was identified on 10/21/25, the CICP should have been updated to reflect an actual impairment. The DON further stated that new preventive and treatment interventions should have been included in the CICP.Despite identification of the new skin issue and initiation of treatment interventions on 10/21/25, the facility did not update or revise the resident's CICP to reflect the new skin integrity concern and corresponding interventions.The facility policy dated 6/2025 and titled, Care Plans-Comprehensive indicated that an individual comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs was developed for each resident. Each resident's care plan was designed to aid in preventing or reducing declines in the resident's functional status