STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315529	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE , EAST HANOVER, New Jersey, 07936**

(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
F0000	INITIAL COMMENTS INITIAL COMMENTS Complaints: 2707766, 2597225 Survey Date: 02/20/2026 Census 75 Sample: 18 + 3 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.	F0000		03/06/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by:	F0812	F812-F – Food Procurement, Store/Prepare/Serve-Sanitary How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? On 2/17, upon identification from the surveyor and instruction from the Culinary Director, DA #1 donned a [redacted] and DA #2 and #3 removed dangling earrings and necklace. On 2/17, upon identification from the surveyor, the Culinary Director removed and discarded two bags of french fries, two bags of hash browns, and one package of lemon bars from the walk-in freezer that were found opened without open or use-by labels. On 2/17, upon identification from the surveyor, the Culinary Director removed and discarded pineapple chunks, anchovies paste, red salsa, and fingerling potatoes from the walk-in refrigerator that were found opened without open or use-by labels. Later that day, maintenance team removed the covers from the fans and thoroughly cleaned the dust-like build up.	03/06/2026

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F0812 SS = F	Continued from page 1 Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 2/17/26 at 7:42 AM, in the presence of the [US FOIA (b)(6)], the surveyor observed the following: 1. One dietary aide (DA#1) with [NJ Exec Order 26.4(b)] not wearing a [NJ Exec Order 26.4b1] two dietary aides (DA#2 and DA#3) wearing dangling earrings and DA#2 also wearing a dangling necklace. Per the [US FOIA (b)(6)] all [NJ Exec Or] hair needs to be covered with a [NJ Exec Ord] [NJ Ex Order] and any jewelry worn should not dangle. 2. In the walk-in freezer, the surveyor observed two bags of French fries, two bags of hash browns and one package of lemon bars all opened without open or use-by labels. The [US FOIA] stated any food product that has been opened needs to have a label that indicates an open and/or use by date. 3. In the walk-in refrigerator, the surveyor observed a clear container containing pineapple chunks, a 12-ounce (oz) jar of anchovies paste, a 32oz container of red salsa, and a plastic bag of fingerling potatoes, all had been opened without an open and/or use-by labels. The surveyor further observed three refrigerator fans with a blackish dust-like build up. The [US FOIA] stated every open container should be labeled, and the fans were scheduled to be clean that week. 4. In the two-door refrigerated deli station, the surveyor observed a container of potato salad that was not labeled with a created and/or use by date. 5. In the cooking area of the kitchen, the surveyor observed on top of two-door standing oven and standing steamer a buildup of a sticky substance. Per the [US FOIA (b)(6)] all cooking equipment is cleaned weekly. 6. On 2/18/26 at 11:08 AM, during the follow-up kitchen tour, the surveyor observed Chef #1 with [NJ Exec Order 26.4(b)] not wearing a [NJ Exec Order 26.4b1]. The [US FOIA] spoke with Chef #1, and a [NJ Exec Order 26.4b1] was put on. On 2/19/26 at 8:30 AM, the [US FOIA (b)(6)] provided the surveyor with three facility policies. The culinary dress code policy with a reviewed date of 9/9/25	F0812	Continued from page 1 On 2/17, upon identification from the surveyor, the Culinary Director removed and discarded one container of potato salad from the two-door refrigerated deli station that was found not labeled with a created and/or use-by date. On 2/17, upon identification from the surveyor, the Culinary Director cleaned the substance from the top of the two-door standing oven and the standing steamer. On 2/18, upon identification from the surveyor and instruction from the Culinary Director, Chef #1 donned a [NJ Exec Order 26.4b1]. How the facility will identify other residents having the potential to be affected by the same practice? All residents have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 2/19/26, the Chief Operating Officer and the Culinary Director re-educated all culinary staff on following policies and procedures: Dress Code, Food Labeling, Sanitization, and other culinary initiatives. Education will be included in new hire orientation and onboarding for all culinary staff. The Culinary Director and/or his designee will conduct daily audits of Dress Code and Sanitization practices to ensure food product contents are not exposed to adulteration or potential contaminates. Any identified deficient practice will be corrected immediately. The Culinary Director and/or his designee will conduct daily audits of Food Labeling practices in all food storage locations to ensure the storage, preparation, distribution and serving of food is in accordance with professional standards of food service safety. Any identified deficient practice will be corrected immediately.	03/06/2026

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F0812 SS = F	Continued from page 2 revealed, "Required Attire: 1. All culinary staff must wear: d. Beard guard (if applicable) ...Jewelry Restrictions. 1. Prohibited. b. Dangling earrings, c. Dangling necklaces." The culinary food labeling policy with a reviewed date of 6/15/25 revealed, "General Labeling Requirements. 1. All prepared, opened, or repackaged food items must include: a. Name of the food items, b. Date prepared, or date opened, c. Use-by/discard/expiration date." The culinary sanitization policy with a reviewed date of 6/11/25 revealed, "3. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions." On 2/19/26 at 12:52 PM, the surveyor met with the US FOIA (b)(6) [redacted] o review concerns found during the survey. The [redacted] stated all concerns in the kitchen would be addressed immediately. On 2/20/26 at 11:37 AM, the surveyor met with the US FOIA (b)(6) [redacted] for the exit conference. The [redacted] provided copies of in-services for the kitchen concerns that were mentioned on 2/19/26. No further information provided. NJAC 8:39-17.2(g)	F0812	Continued from page 2 Audit logs will be implemented on 3/9/2026 to ensure compliant practice. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur? The Culinary Director and/or his designee will conduct such audits daily x 4 weeks and then weekly x 8 weeks. The Culinary Director will submit the audit findings to the Administrator and/or her designee for weekly review. The Culinary Director will submit the audit findings at the next QAPI meeting. The QAPI committee will determine when compliance is sustained, and whether further action is necessary. Completion Date: 3/11/2026	03/06/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F0686	F0686-D – Treatment/Services to Prevent/Heal Pressure Ulcer How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? On [redacted] upon identification from the surveyor, the Director of Nursing adjusted the [redacted] for resident #12 and resident #9 to appropriately reflect the residents' most recent [redacted] On 2/19/26, Director of Nursing completed a review of all specialty mattresses to confirm that such mattresses were set to the appropriate weight for each respective resident and functioning properly. How the facility will identify other residents having	03/11/2026

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F0686 SS = D	Continued from page 3 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that a NJ Exec Order 26.4b1 was accurately set and monitored based on the resident's NJ Exec Order This deficient practice was identified for 2 of 4 residents reviewed (Resident #9 and #12). This deficient practice was evidenced by the following: 1. On 2/18/26 at 11:00 AM, the surveyor observed resident #12 in bed with a NJ Exec Order 26.4b1 in place. The resident's NJ Exec Order 26.4b1 was set to a NJ Exec Orde of NJ Exec Order 26.4b1 On 2/19/26 at 10:32 AM, the surveyor observed resident #12 in bed with a NJ Exec Order 26.4b1 in place. The resident's NJ Exec Order 26.4b1 was set to a NJ Exec Orde of NJ Exec Order 26.4b1. The surveyor reviewed the medical record for Resident #12. A review of the admission record reflected that the resident was admitted to the facility on NJ Exec Order 2 with diagnoses that included but were not limited to; NJ Exec Order 26.4b1 A review of the current Order Summary Report (OSR) included an active Physician's Order (PO) for NJ Exe monitor function and placement every shift. A review of the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 2 reflected that Resident #12 had a brief interview of mental status score of "NJ B of 15," which indicated Resident #12's NJ Exec Order 26.4b1. The MDS further noted that Resident #12 NJ Exec Order 26.4b1 and had a NJ Exec Order 26.4b1 on their bed and chair. A review of Resident #12's NJ Exec Order 26.4b1 showed that the resident's most recent NJ Exec Orde was NJ Exec A review of Resident #12's current Treatment Administration Record (TAR) revealed the PO for an NJ Exec Order 26.4b1 was transcribed onto the TAR with instructions to monitor for function and placement	F0686	Continued from page 3 the potential to be affected by the same practice? All residents requiring specialty mattresses have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 2/19/26, the Director of Nursing and Assistant Director of Nursing began re-education all professional nursing staff on the proper use and settings of specialty mattresses. This education was completed with all consistently working professional nursing staff members by 2/25/26 and is ongoing for all per diem professional nursing staff. The Director of Nursing and/or his designee will conduct weekly audits of specialty mattress setting and functionality to ensure proper utilization. An audit log was implemented on 2/27/2026 to ensure compliant practice. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur? The Director of Nursing and/or his designee will conduct such audits weekly x 12 weeks. The Director of Nursing and/or his designee will submit the audit findings to the Administrator and/or her designee for weekly review. The Director of Nursing will submit the audit findings at the next QAPI meeting. The QAPI committee will determine when compliance is sustained, and whether further action is necessary. Completion Date: 3/11/2026	03/11/2026

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F0686 SS = D	Continued from page 4 every shift, and was signed by the nurses every shift. A review of Resident #12's Care Plan Report identified a Focus area: a history of [redacted], with interventions that included, but were not limited to, providing a [redacted] for the bed. On 2/19/26 at 11:00 AM, during an interview with the surveyor, the [redacted] confirmed that the [redacted] was set at [redacted]. The surveyor asked the [redacted] the resident's [redacted] and whether the [redacted] should be set to that [redacted] The [redacted] replied that she was not sure of the resident's [redacted] and that she had no idea what the [redacted] should be set at because it was the maintenance department's responsibility to set it up and monitor it. The surveyor asked the [redacted] whether she had signed the TAR, indicating that it was being monitored. The [redacted] did not respond to the surveyor's inquiry. 2. On 2/19/26 at 11:26 AM, the surveyor observed Resident #9 in bed on a [redacted]. The surveyor observed that the resident's [redacted] was set to a [redacted] of [redacted]. The [redacted] confirmed the [redacted] was set to [redacted] and again stated she had no idea what the [redacted] should be set at, as the maintenance department was fully responsible for the setup and monitoring of the [redacted] The surveyor reviewed Resident #9's medical record. A review of the Admission Record reflected that the resident was admitted to the facility on [redacted] with diagnoses that included but were not limited to [redacted] and [redacted] A review of the current OSR included an active PO [redacted] monitor function and placement every shift. A review of the quarterly MDS dated [redacted] reflected Resident #9 had a BIMS score of [redacted] of 15," which indicated Resident #9's [redacted] The MDS further reflected the resident's [redacted] was [redacted], and the resident had a [redacted] for their bed and chair.	F0686		03/11/2026

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F0686 SS = D	Continued from page 5 A review of Resident #9's [NJ Exec Order 26.4b1] showed that the resident's most recent [NJ Exec Orde] was [NJ Exec Ord] [redacted] A review of Resident #9's current TAR revealed the PO for the [NJ Exec Order 26.4b1], transcribed onto it, with instructions to monitor function and placement every shift, and was signed by the nurses. A review of Resident #9's Care Plan Report identified a Focus area indicating the resident had a history of [NJ Exec Order 26.4b1], with interventions that included, but were not limited to, providing a [NJ Exec Order 26.4b1] for the bed. On 2/19/26 at 12:52 PM, the survey team met with the [US FOIA (b)(6)] [redacted] to discuss the above observations and concerns. The [US FOIA (b)(6)] confirmed that when the nurses signed the TARs, it indicated that they had been monitoring the [NJ Exec Order 26.4b1] and ensuring they were set to the Resident's [NJ Exec Order]. On 2/20/26 at 9:20 AM, during an interview with the surveyor, the [US FOIA (b)(6)] stated that the maintenance staff was responsible for setting up the [NJ Exec Order 26.4b1], and then the nurses monitored them. A review of the facility's policy: Support Surface Guidelines reviewed 7/2/25 reflected…The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown…The support surface will be adjusted per the resident's weight and physician's order… On 2/20/26 at 9:39 AM, no further information was provided. NJAC: 8:39 27.1 (a)	F0686		03/11/2026
F0640 SS = B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:	F0640	F0640-B – Encoding/Transmitting Resident Assessments How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? Director of Clinical Reimbursement completed the	03/15/2026

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F0640 SS = B	Continued from page 6 (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.	F0640	Continued from page 6 outstanding quarterly MDS assessment for resident #27 and transmitted such on [redacted]. Director of Clinical Reimbursement completed a review of all current charts to identify any outstanding assessments. All outstanding assessments were completed by end of business day on 2/24/2026. How the facility will identify other residents having the potential to be affected by the same practice? All residents have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 2/19/26, the Assistant Administrator re-educated the [redacted] on Timely Submission of MDS. This education included the instruction to inform the Administrator when additional budgeted resources will be utilized to the ensure timely completion of MDS assessments. On 2/19/26, the Assistant Administrator re-educated respective team members, inclusive of respective department heads and/or their designees, who are responsible for the timely completion of the MDS. The Director of Clinical Reimbursement will conduct daily audits of MDS assessments to ensure the timely completion of such assessments. Any identified deficient practice will be immediately brought to the attention of the respective team member and administrator, and corrective action will be taken as deemed necessary. An audit log will be implemented on 3/9/2026 to ensure compliant practice. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur?	03/15/2026

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F0640 SS = B	Continued from page 7 This REQUIREMENT is NOT MET as evidenced by: Based on the interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS, an assessment tool used to facilitate the management of care) in accordance with federal guidelines. This deficient practice was identified for 3 of 18 residents (Resident #27, #50, and #91) during the review of resident assessment. This deficient practice was evidenced by the following: The MDS is a comprehensive tool, a federally mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of completing the assessment. After the MDS is transmitted, a quality measure will be transmitted to enable a facility to monitor the residents' decline or progress. On 2/17/26 at 11:30 AM, the surveyor provided the US FOIA (b)(6) with the list of 3 residents who had not completed an MDS in over 14 days. The surveyor also requested a copy of the resident's final validation report (generated after every MDS transmission) from the Centers for Medicare and Medicaid Services (CMS). On 2/19/26 at 10:59 AM, the surveyor interviewed US FOIA (b)(6) she was aware that there were MDS assessments that were late. The surveyor reviewed the final validation report from CMS with the U.S. FOIA (b) (6) the 3 residents' MDS assessments that were not submitted within fourteen days of completion, as follows: 1. Resident #27 had a Quarterly MDS assessment with an assessment reference date (ARD, the last day of the observation period) of NJ Exec Order 2 but was not transmitted until NJ Exec Order 2. (Submission was 24 days late). 2. Resident #50 had a Quarterly MDS assessment with an ARD, of NJ Exec Order 25 but was not transmitted unti NJ Exec Order 25 (Submission was 33 days late).	F0640	Continued from page 7 The Director of Clinical Reimbursement will conduct such audits daily x 4 weeks and then weekly x 8 weeks. The Director of Clinical Reimbursement will submit the audit findings to the Administrator and/or her designee for weekly review. The Director of Clinical Reimbursement will submit the audit findings at the next QAPI meeting. The QAPI committee will determine when compliance is sustained, and whether further action is necessary. Completion Date: 3/06/2026	03/15/2026

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F0640 SS = B	Continued from page 8 3. Resident #91 had an Annual MDS assessment with an ARD, of [NJ Exec Order 2] but was not transmitted until [NJ Exec Order 2]. (Submission was 9 days late.) On 2/19/26 at 11:50 AM, the surveyor reviewed policy titled, "MDS—Completion and Submission Timeframe," dated, 9/25/25, which revealed…the assessments coordinator or designee is responsible for ensuring resident assessments are submitted to Center of Medicare and Medicaid Services' internet Quality Improvement Evaluation System (iQIES) in accordance with current federal and state guidelines. On 2/19/26 at 12:10 PM, the surveyor reviewed policy titled, "MDS—Electronic Transmission," dated, 9/25/25, which revealed…all MDS assessments (admission, annual, significant change, quarterly review, discharge and reentry records are completed and electronically encoded into the facilities MDS information system and transmitted in accordance with current regulations governing the transmission of MDS data. On 2/19/26 at 12:56 PM, the surveyor met with the [US FOIA (b)(6)] to review concerns found during the survey. The [US FOIA (b)(6)] stated Admission, Quarterly and Annual MDS should be completed within 14 days of the ARD. On 2/20/26 at 12:06 PM, the surveyor team met with the [US FOIA (b)(6)]. No further pertinent information was provided. NJAC 8:39-11.1	F0640		03/15/2026

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH14002	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE , EAST HANOVER, New Jersey, 07936**

(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
S0000	Initial Comments Complaint #s NJ: 437265 Survey Date: 2/17/26 - 2/20/26 Census:75 Sample: 18+ 3 Closed Records The facility is in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities.	S0000		03/06/2026

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315529	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE , EAST HANOVER, New Jersey, 07936**

(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
F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 03/17/2026 in relation to the 02/20/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further 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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH14002	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE , EAST HANOVER, New Jersey, 07936**

(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
S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 03/17/2026 in relation to the 02/20/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315529	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **02/20/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE , EAST HANOVER, New Jersey, 07936**

(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
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 02/17/2026 and 02/18/2026 and the facility 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 18 NEW Health Care occupancy. Livia Health and Senior Living is a four-story building that was constructed in 2020. It is composed of Type II (222) construction. The facility is divided into six smoke compartment. The Natural gas generator powers 100% of the building. The facility has a complete automatic sprinkler system. The number of Occupied beds was75 out of 86 Licensed beds.	K0000		03/09/2026
K0271 SS = F Bldg. 01	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is NOT MET as evidenced by: Based on observations, interview and review of facility provided documentation on 02/17/2026 in the presence of the facility's US FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that 3 of 5 designated exit discharge paths were maintained free of all obstructions and impediments to reach a public way (street or parking lot) in the case of fire or other emergency in accordance with National Fire Protection Association	K0271	K0271 – F – Discharge From Exits How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? Upon notification from the surveyor, on 2/17/26, the Environmental Services Director and his team cleared the remaining snow from the following designated paths of egress to ensure a hardpacked all weathered travel surface to the public way. Patio Area: 40' of discharge path cleared Residents' Bistro: 20' of discharge path cleared Community Room: 18' of discharge path cleared The Environmental Services Director and his team assessed all exit doors to ensure each one had a	03/09/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315529	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **02/20/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE , EAST HANOVER, New Jersey, 07936**

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K0271 SS = F Bldg. 01	Continued from page 1 (NFPA) 101, 20123 Edition, Section 19.2, 18.2.1, 18.2.7, 7.7, 7.7.1, 7.7.3.2, 7.1.6, 7.1.6.2, 7.1.6.3, 7.1.10, 7.1.10.1. This deficient practice had the potential to affect the 75 Residents and was evidenced by the following: A review of the facility provided Lower Level lay-out identified there are 5 designated exit (illuminated exit signs above the doors) discharge doors on this level that Residents, Visitors and Staff could use in the event of an emergency. Observations on 02/17/2026: At approximately 10:12 AM, outside of the designated exit discharge door leading to the Patio area, the surveyor observed an approximately 6 inches of snow blocking the approximately 40 feet discharge path to reach a public way. At approximately 10:35, outside the Residents Bar room exit discharge door, the surveyor observed an approximately 7 to 8 inches of snow blocking the 20 feet discharge path to reach a public way. At approximately 10:41 AM, the surveyor observed outside of the Community room's exit discharge door an approximately 7 inches of snow blocking the approximately 18 feet discharge path to reach a public way. During an interview with the [redacted] he confirmed that the discharge paths need to be cleaned of the snow. The [redacted] were informed of the deficient practice during the Life Safety Code survey exit at approximately1:20 PM on 02/18/2026. NJAC 8:39-31.2 (e).	K0271	Continued from page 1 free and unobstructed egress on 2/17/26. No other deficient practice was identified. How the facility will identify other residents having the potential to be affected by the same practice? All residents have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The [redacted] and maintenance team were re-educated by the Regional Plants Operations Director on 2/17/26 regarding the requirement that all exit doors must have a free and unobstructed path of egress. Administrator and/or her designee will proactively communicate with the Environmental Services Director prior to any anticipated weather related event that could potentially obstruct all paths of egress. Administrator and/or her designee will audit such exits during and post weather related event. Any identified deficient finding will be corrected immediately. An audit log will be implemented on 3/9/2026 to ensure compliant practice. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur? The Administrator and/or her designee will conduct an audit of all exits during and post weather related events for the remainder of the year (2026). The Administrator and/or her designee will submit the audit findings at the following quarterly Quality Assurance Performance Improvement meetings (QAPI): Q1 4/13/26, Q2 7/2026, Q3 10/2026, Q4 1/2027. The QAPI committee will determine when	03/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315529	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **02/20/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE , EAST HANOVER, New Jersey, 07936**

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K0271 SS = F Bldg. 01		K0271	Continued from page 2 compliance is sustained, and whether further action is necessary. Completion Date: 3/9/2026	03/09/2026
K0531 SS = E Bldg. 01	Elevators CFR(s): NFPA 101 Elevators 2012 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 18.5.3, 9.4.2, 9.4.3 This STANDARD is NOT MET as evidenced by: Based on observations, interview and review of facility provided documentation on 02/17/2026 and 02/18/2026 in the presence of the facility's [redacted], it was determined that the facility failed to provide and maintain emergency communications in proper working condition for 2 of 3 elevators tested in accordance with NFPA 101, 2012 Edition, Section 18.5.3, 9.4.2, 9.4.3 and ASME/ANSI A17.3. This Deficient practice had the potential to affect the 75 Residents, Visitors and Staff in the facility and was evidenced by the following: In an interview on 02/17/2026 during the Life Safety Code survey entrance at approximately9:30 AM, the Facility's [redacted] stated that there are three (3) elevators in the facility. Observations and interview on 02/17/2026 revealed the following: At approximately 11:09 AM during a test of elevator #3 emergency communication phone revealed when tested there was no pre-recorded message giving	K0531	K0531 – E – Elevators How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? Elevator #3: On 3/12/26, the facility's elevator contractor programmed the emergency communication device to provide a pre-recorded message upon activation. This message includes the facility's physical address and elevator number (3) to ensure automatic locations for required monitoring compliance. Emergency communication will be transferred to the reception desk for immediate attention, and then to the nursing supervisor's dedicated phone for any shift or time when reception is not actively present at the reception desk. Elevator #2: The emergency communication phone in Elevator #2 was inspected on 2/18/26 by the Environmental Services Director. On 3/12/26, the facility's elevator contractor repaired the malfunctioning hardware to restore full two-way voice communication and 24/7 connectivity. The pre-recorded message, inclusive of the facility's physical address and elevator number (2), were confirmed to be fully operational. Emergency communication will be transferred to the reception desk for immediate attention, and then to the nursing supervisor's dedicated phone for any shift or time when reception is not actively present at the reception desk. How the facility will identify other residents having the potential to be affected by the same practice? All residents have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	03/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315529	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	1 SOUTH RIDGEDALE AVENUE , EAST HANOVER, New Jersey, 07936

(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
K0531 SS = E Bldg. 01	Continued from page 3 the address of the facility and elevator number to the monitoring company. Observation and interview on 02/18/2026: At approximately 10:30 AM, during a test of elevator #2 emergency communication phone revealed when tested did not function properly. At this time the [redacted] told the surveyor that the elevator had failed the annual inspection for the emergency communication phone not working. Review of the facility provided annual inspection dated 07/18/2025 of the three elevators identified that elevator #2 emergency communication phone was identified as Unsatisfactory. Interviews with the [redacted] at the times of the observations confirmed both findings. Th [redacted] were informed of the deficient practice during the Life Safety Code survey exit at approximately 1:20 PM on 02/18/2025. NJAC 8:339-31.2 (e).	K0531	Continued from page 3 The Environmental Services Director conducted an immediate audit of the remaining elevator, Elevator #1, on 2/18/26 to verify both physical phone function and the presence of the required pre-recorded location identification message. The Regional Plants Operational Director provided education to [redacted] and maintenance staff on the requirements of pre-recorded communication devices inclusive of location message for all elevator phones on 2/18/26. The Environmental Services Director or his designee will conduct weekly audits to confirm proper functioning of automatic caller identification. Audits will be submitted to the Administrator for review on a weekly basis. Any identified deficient finding will be reported to the Administrator and corrected immediately. An audit log will be implemented on 3/13/2026 to ensure compliant practice. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur? The Environmental Services Director and/or his designee will conduct weekly audits x 4 weeks, and then monthly audits x 2 months. The Environmental Services Director will submit the audit findings at the following quarterly Quality Assurance Performance Improvement meetings (QAPI): Q1 4/13/26, Q2 7/2026. The QAPI committee will determine when compliance is sustained, and whether further action is necessary. Completion Date: 3/13/2026	03/13/2026
K0355 SS = D Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA	K0355	K0355 – D – Portable Fire Extinguishers How any corrective action will be accomplished for those residents found to have been affected by the deficient practice?	03/11/2026

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K0355 SS = D Bldg. 01	Continued from page 4 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation on 02/17/2026, in the presence of the facility's US FOIA (b)(6) it was determined that the facility failed to perform a monthly visual examination and document the inspection on the tag attached to the fire extinguisher for 1 of 18 fire extinguishers inspected in accordance with the National Fire Protection Association (NFPA) 10, 2010 Edition, section 10.7.2.4.1.4. This deficient practice had the potential to affect the 76 Residents in the facility and was evidenced by the following: Observations on 02/17/2026 and 02/18/2026 in the presence of the facility's US FOIA (b) revealed 18 fire extinguishers in various locations with the following results; On 02/17/2026 at approximately 9:47 AM, the surveyor observed one (1) ABC type fire extinguisher in the corridor outside of the main kitchen. This fire extinguisher was last annually inspected April 2025 with no evidence of a monthly visual examination being performed and documented on the inspection tag attached to the extinguisher for May, June, July and August 20025. The US FOIA (b) confirmed the finding at the time of observation. The US FOIA (b)(6) were informed of the deficient practice during the Life Safety Code survey exit at approximately 1:20 PM on 02/18/2026. NJAC 8:39-31.2 (c), -31.2 (e), NFPA 10.	K0355	Continued from page 4 The Environmental Services Director and his designee conducted a building wide audit of all fire extinguishers to ensure compliance with monthly inspections on 2/18/26. The annual inspection of all fire extinguishers was completed on 3/11/26 by the contracted vendor, and respective fire extinguisher inspection tags were replaced for the current year. How the facility will identify other residents having the potential to be affected by the same practice? All residents have the potential to be affected by this deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The US FOIA (b)(6) was re-educated by the Regional Plants Operations Director on the requirements regarding the monthly visual inspection of all fire extinguishers on 2/18/26. The Environmental Services Director re-educated all maintenance staff members on the requirements regarding the monthly visual inspection of all fire extinguishers on 2/18/26. The Environmental Services Director or his designee will conduct monthly audits to confirm compliance with monthly visual fire extinguisher inspections. Audits will be submitted to the Administrator for review on a monthly basis. Any identified deficient finding will be reported to the Administrator and corrected immediately. An audit log will be implemented on 3/11/2026 to ensure compliant practice. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur? The Environmental Services Director and/or his	03/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315529	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **02/20/2026**

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LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE , EAST HANOVER, New Jersey, 07936**

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K0355 SS = D Bldg. 01		K0355	Continued from page 5 designee will conduct monthly audits for the remainder of the year (2026). The Environmental Services Director will submit the audit findings at the following quarterly Quality Assurance Performance Improvement meetings (QAPI): Q1 4/13/26, Q2 7/2026, Q3 10/2026, Q4 1/2027. The QAPI committee will determine when compliance is sustained, and whether further action is necessary. Completion Date: 3/11/2026	03/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315529	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

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E0000	Initial Comments An Emergency Preparedness survey was conducted by the New Jersey department of Health, Health Facility Survey and Field Operations on 02/17/2026 and 02/18/2026. Livia Health and Senior Living was found to be in noncompliance with Medicare/Mediciad at 42 CFR Subpart 483.73, Requirements for Long Term Care Facilities.	E0000		03/09/2026
E0004 SS = E	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan.	E0004	E004-E – Develop EP Plan, Review and Update Annually How any corrective action will be accomplished for those residents found to have been affected by the deficient practice? On 2/18/26, after identification from the surveyor, the Administrator reviewed the signature page in the Disaster Manual with the Director of Environmental Services. On 1/29/26, the NJ Exec Order 26.4b1 rendered an abatement of non-compliance due to the receipt of Emergency Plan. On 3/2/26, the Director of Environmental Services met with NJ Exec Order 26.4b1 Police Chief and NJ Exec [redacted] OEM to confirm previous receipt and review of Emergency Plan. The attached Disaster Manual signature page certifies the presence of the included team members and local officials during the disaster drill on 10/21/2025, as well as their acknowledgment that such plan was reviewed. How the facility will identify other residents having the potential to be affected by the same practice? All residents have the potential to be affected by this	03/10/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315529	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

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LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE , EAST HANOVER, New Jersey, 07936**

(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
E0004 SS = E	Continued from page 1 The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility documentation on 02/17/2026 and 02/18/2026, in the presence of the facility US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that the Emergency Preparedness Plan (EPP) were reviewed and updated at least annually. This deficient practice had the potential to affect the 75 residents in the facility and was evidenced by the following: In an interview during the survey entrance on 02/17/2026 at approximately 9:30 AM, a request was made to the [redacted] "How many Emergency Preparedness Plan (EPP) books are in the facility and where are they located?" The [redacted] told the surveyor that there are three (3) EPP books in the facility. One (1) at the second floor Nursing Station, one (1) at the third floor Nursing Station and one (1) in the Administration Office. On 02/18/2026 at approximately 11:28 AM, a review of the Administrative Office book provided to the surveyor reads in part: Disaster Manual, signature page, "This is to certify that the 2025 Livia Health and Senior Living Emergency Plan was reviewed by the following persons: Administrator- No Signature or date. Environmental Services director- No signature or date. Director of Nursing- No signature or date, Assistant Director of Nursing- No signature or date. East Hanover OEM- No signature or date. East Hanover Police Chief- No signature or date. At approximately 12:20 PM, a review of the third floor Nursing Station Disaster Manual revealed on the signature page had no signatures or dates.	E0004	Continued from page 1 deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The US FOIA (b)(6) [redacted] was re-educated by the Administrator on 2/18/26 regarding the requirement to have the Disaster Manual reviewed annually, and as needed, by the leadership team and township officials with certification on the corresponding signature page. The Environmental Services Director and/or his designee will conduct monthly audits of Disaster Manual locations and entirety to ensure the facility's emergency plan is readily available. Any identified deficient practice will be corrected immediately. An audit log will be implemented on 3/10/2026 to ensure compliant practice. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur? The Environmental Services Director and/or his designee will conduct such monthly audits for the remainder of this year (2026). The Environmental Services Director will submit the audit findings at the following quarterly Quality Assurance Performance Improvement meetings (QAPI): Q1 4/13/26, Q2 7/2026, Q3 10/2026, Q4 1/2027. The QAPI committee will determine when compliance is sustained, and whether further action is necessary. Completion Date: 3/10/2026	03/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315529	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE , EAST HANOVER, New Jersey, 07936**

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E0004 SS = E	Continued from page 2 At approximately 12:28 PM, a review of the second floor Nursing Station Disaster Manual revealed on the signature page had no signatures or dates. At approximately 12:52 PM, the US FOIA (b)(6) confirmed the findings. The US FOIA (b)(6) were informed of the deficient practice during the Life safety Code survey exit at approximately 1:20 PM on 02/18/2026. NJAC 8:39-31.2 (e).	E0004		03/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315529	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **03/17/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE , EAST HANOVER, New Jersey, 07936**

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 03/17/2026 in relation to the 02/20/2026 Life Safety Code survey. The facility was found to be in compliance 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 Occupancy.	K0000		

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315529	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE , EAST HANOVER, New Jersey, 07936**

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E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 03/17/2026 in relation to the 02/20/2026 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		

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 reverse for further 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