STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315479	A. BUILDING _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	**68 PASSAIC AVENUE LIVINGSTON, NJ 07039**

(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
F 000	INITIAL COMMENTS Complaint #s: NJ 154054, 162302, 162357, 162411, 163471, 163604, 164470, 164814, 165442, 167384 STANDARD SURVEY: 3/14/24 CENSUS: 58 SAMPLE SIZE: 24 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 640 SS=E	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: (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	F 640		3/29/24

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

Electronically Signed | 03/27/2024

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F 640	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to a.) electronically transmit the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, within 14 days of completing the resident's assessment and in accordance with the Center's for Medicare and Medicaid Services (CMS) Resident	F 640	In-service conducted with MDS staff on timely submission regarding Residents 25, 26, and 39. Resident 48 no longer residents in the facility. A discharge assessment with an Assessment Reference Date (ARD) of [redacted] was opened for Resident 48 by the US FOIA (b)(6) on [redacted]. MDS	

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F 640	Continued From page 2 Assessment Instrument (RAI) Manual. This deficient practice was identified for 3 of 24 residents (Resident #25, 26, and #39), and b.) complete the discharge assessment for 1 of 24 residents (Resident #48) reviewed for resident assessment. The deficient practice was evidenced by the following: 1. On 3/4/24 at 10:30 AM, the surveyor observed Resident #25 out of bed in a NJ ex order 26.4b1 NJ Exec O and NJ Exec Order 26.4b sitting in the activity room. The surveyor reviewed Resident #25's medical record. A review of the Admission Record (an admission summary) (AR) documented that Resident #25 was admitted to the facility with diagnoses that included but were not limited to NJ ex order 26.4b1 . The resident's most recent Quarterly MDS (QMDS) assessment, dated NJ ex order 26.4b1 reflected that Resident #25 had a Brief Interview for Mental Status (BIMS) score of NJ ex o out of 15, indicating NJ ex order 26.4b1 Resident #25 was observed to have a QMDS with an Assessment Reference Date (ARD) on NJ ex order 26.4b1 The assessment was completed and will be transmitted no later than NJ ex order 26.4b1 However, the QMDS was not submitted until NJ ex order 26.4 A review of the undated "Final Validation Report" for Resident #25, provided by the US FOIA (b) , revealed that "Warning Assessment Completed Late:" is more than 14 days after ARD.	F 640	assessment was completed by the Interdisciplinary Team on NJ Exec Order 26 and was submitted by the US FOIA (b)(6) to the iQIES on NJ Exec Order 26 Validation report was generated from the CASPER system to confirm successful submission and acceptance of the Discharge MDS Assessment by CMS. Residents 25, 26, 39, and 48 were not adversely affected by this practice. All residents have the potential to be affected by this deficient practice. Regional MDSC/RN completed the DOH roster to the daily census to identify any other resident findings. The Regional MDSC/RN also generated the CASPER Report for Missing MDS Assessments to identify any other residents affected by the same practice. Completed MDS assessments in the past 4 months were cross-referenced with the validation reports to make sure that the MDS assessments were successfully submitted and accepted in the CMS system. The action summary/census run daily for verification of assessments needing to be opened with appropriate ARD date as indicated. Hiring full-time MDS Coordinator is prioritized. In the interim, MDS Coordinator or designee will submit assessments weekly to iQIES and review Validation Reports. They will also compare the daily census with the DOH roster monthly to ensure no assessments are missing and validate the action	

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F 640	Continued From page 3 2. On 3/4/24 at 11:42 AM, the surveyor observed Resident #26 sitting in a wheelchair inside the room beside the [redacted]. The surveyor reviewed Resident #26's medical record. A review of the AR documented that Resident #26 was admitted to the facility with diagnoses that included but were not limited to [redacted]. The resident's Admission MDS (AMDS) assessment, dated [redacted], reflected that Resident #26 had a BIMS score of [redacted] out of 15, indicating [redacted]. A review of AMDS with an ARD on [redacted]. The assessment was completed and will be transmitted no later than [redacted]. However, the AMDS was not submitted until [redacted]. A review of the undated "Final Validation Report" for Resident #26, provided by the [redacted] revealed "Warning Assessment Completed Late:" for this admission assessment is more than 13 days after the entry date. 3. On 3/4/24 at 10:00 AM, the surveyor observed Resident #39 standing beside the bed fixing the bedsheet. The resident [redacted] with the surveyor. The surveyor reviewed Resident #39's medical record. A review of the AR documented that Resident #39 was admitted to the facility with diagnoses which included but was not limited to unspecified	F 640	summary census daily for assessments being opened, so the appropriate assessments are completed accordingly. MDS staff and IDCP team were educated on the regulations governing F640: Encoding/Transmitting Resident Assessments. Focus was made on timely completion of MDS assessments and the Transmittal Requirements. The MDS Coordinator or designee will conduct 5 audits per week x 4 weeks, then 5 audits per month x 3 months to ensure timely submission of the MDS. The MDS Coordinator or designee will provide results of all audits to the Quality Assurance Committee on a monthly basis for a period of 3 moths to ensure 100% compliance, at which time it will be determined if further audits are needed.	

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NJ ex order 26.4b1 The resident's most recent QMDS assessment, dated NJ ex order 26.4b1, reflected that Resident #39 had a BIMS score of NJ out of 15, indicating NJ ex order 26.4b1

Resident #39 was observed to have an Annual MDS with an ARD on NJ ex order 26.4b1 The assessment was completed and will be transmitted no later than NJ ex order 26.4b However, the Annual MDS was not submitted until NJ ex order 26.4b1.

A review of the undated "Final Validation Report" for Resident #39, provided by the US FOIA (b)(6) revealed that "Warning Assessment Completed Late:" is more than 14 days after ARD.

Resident #39 was observed to have a QMDS with an ARD on NJ ex order 26.4b The assessment was completed and will be transmitted no later than NJ ex order 26.4 However, the QMDS was not submitted until NJ ex order 26.4

A review of the undated "Final Validation Report" for Resident #39, provided by the US FOIA (b)(6), revealed "Warning Assessment Completed Late:" is more than 14 days after ARD.

On 3/8/24 at 11:20 AM, the surveyor interviewed the US FOIA (b)(6), who stated that he is working NJ Exec Order 26.4b. The US FOIA (b)(6) stated that they had not had a full time US FOIA (b)(6) since NJ Exec Order 26.4b1 NJ Exec Or and added that the position is still not filled.

On 3/11/24 at 11:24 AM, the surveyor interviewed the US FOIA (b)(6) over the phone and stated she was aware that the assessments were all late. She is the one who pulled out the final validated reports, and they showed late. They

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F 640		F 640		

Continued From page 5

haven't had a full US FOIA (b)(6) since NJ Exec Order 26.4b1 NJ Exec Orde There's one NJ Exec Order 26.4b1 US FOIA (b) who is doing remote work. The full-time regionals look at the assessments and check if there are some due.

4. On 3/7/24 at 10:39 AM, the surveyor reviewed the electronic medical record for Resident #48.

The medical record reflected the resident was admitted to the facility on NJ ex order 26.4b1 and was discharged home with a family member on NJ Exec Order 26.4b

The surveyor reviewed the resident's electronic MDS records. The records reflected Entry/MDS NJ ex order 26.4b1 , NJ ex order 26.4b1 The record did not reflect a discharge MDS.

On 3/11/24 at 11:26 AM, the surveyor interviewed the US FOIA (b)(6) by phone and stated she is accessed the record now and agreed that there was no discharge MDS present. She stated that she would open a discharge MDS right away.

On 3/11/24 at 01:35 PM, the survey team met with the US FOIA (b)(6) and US FOIA (b)(6), and the facility management provided no additional information.

According to the Long-Term Care Facility RAI 3.0 User's Manual Version 1.18.11, updated October 2023, the MDS is a comprehensive tool that is a federally mandated process for clinical assessment of all residents that must be

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F 640	Continued From page 6 completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of the assessment being completed. After the transition of the MDS, a quality measure will be transmitted to enable a facility to monitor the resident's decline or progress. page 2-11 "Discharge refers to the date a resident leaves the facility..." There are two types of OBRA (Omnibus Budget Reconciliation Act) required discharges: return anticipated and return not anticipated. A Discharge assessment is required with all types of discharges. The manual on Pages 2-17, "A Discharge Assessment - return not anticipated MDS must be completed not later than discharge date + 14 days. The assessment must also be transmitted to the QIES (Quality Improvement and Evaluation System) ASAP (Assessment Submission and Processing) system not later than the MDS completion + 14 days.	F 640		
F 755 SS=E	NJAC 8:39 - 11.1 Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		3/29/24

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F 755	Continued From page 7 dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards by not ensuring administration of a medication, NJ Exec Order 26.4b1 [redacted] according to a physician's order. This occurred for one (1) of five (5) residents, (Resident #21), reviewed for medication management. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through	F 755	An in-service, clinical practice referral and disciplinary action were implemented by the US FOIA (b)(6) with the individual nurse who did not follow up on the delivery of [redacted] for Resident 21 by the US FOIA (b)(6). [redacted] reviewed [redacted] protocol with pharmacy provider. Resident 21 had NJ Exec Order 26.4b1 related to this practice. All residents prescribed Procrit have the potential to be affected by this practice. All residents receiving Procrit will have lab work drawn the day prior to Procrit administration day to provide adequate time for the lab results to be posted. All nurses were re-educated on informing the	

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F 755	Continued From page 8 such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The deficient practice was evidenced by the following: On 3/4/24 at 11:53 AM, the surveyor observed Resident #21 in the facility lobby area NJ Exec Order 26.4b1 him/herself and talking with the receptionist. At that time, the surveyor interviewed Resident #21 at a nearby private area in the lobby. The resident stated that he/she NJ Exec Order 26.4b1 with the care at the facility. The surveyor reviewed the medical record for Resident #21. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool	F 755	DOH and LNHA of any barriers to receiving Procrit from the pharmacy in order for the nurse to receive assistance from facility management in obtaining the necessary medication. All nurses were re-educated on the proper process and how to document when a medication has not arrived from pharmacy: informing the physician, changing the date of the order for a later date if approved by the physician, and/or changing the medication to a compatible substitute if possible. The DON or designee will conduct a weekly audit of the EMAR for all residents on Procrit to ensure that if they required the dosage based on their lab work, that it was administered. The DON or designee will conduct a weekly audit of the EMAR for 100% of the residents on Procrit to ensure the medication was administered per physicians order. DON or designee will review the results of the weekly audit on a monthly basis with the Quality Assurance Committee for a period of 3 months, at which time it will determined if continued monitoring is needed.	

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used to facilitate the management of care dated [NJ ex order 26.4], reflected the resident had a brief interview for mental status (BIMS) score of [NJ ex o] out of 15, indicating that the resident [NJ ex order 26.4b1] [redacted]

A review of the Admission Record revealed diagnoses which included [NJ ex order 26.4b1] [redacted]

A review of the Order Summary Report (OSR) revealed a physician's order (PO) with a start date of [NJ ex order 26.4] for [NJ ex order 26.4b1] [redacted]

A review of the [NJ ex order 26.4b1] electronic Medication Administration Record (eMAR) revealed the corresponding above PO for [NJ ex order 26.4b1] [redacted] The administration documentation on the dates of [NJ ex order 26.4b1] [redacted] indicated the number nine (9) which correlated with the Chart Codes for "Other/See Nurses Notes."

There was no indication on the eMAR as to the Hgb laboratory results that corresponded to the PO.

A review of the electronic nursing Progress Notes (ePN) for [NJ ex order 26.4b1] [redacted]

In addition, the ePN for [NJ Exec Order] administration for the dates of [NJ ex order 26.4b1] indicated "Waiting for supply."

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A review of the resident's [NJ ex order 26.4b1] laboratory results for the following dates revealed:
- a collection dated of [NJ ex order 26.4] and received date of [NJ ex order 26.4b1].
- a collection date of [NJ ex order 26.4] and a received date of [NJ ex order 26.4b1].
- a collection date of [NJ ex order 26.4b1] and a received date of [NJ ex order 26.4b1]

There were no [NJ Exec Order 26.4b1] results found corresponding to the [NJ ex order 26] Procrit administration day which was contradictory to the ePN for [NJ ex order 26]. In addition, the [NJ ex order 26.4] collection date with a received date of [NJ ex order 26.4b1] results had not correlated with the [NJ ex order 26.4b1].

A review of the March eMAR revealed the corresponding above PO for [NJ Exec Order] scheduled for administration at 6 PM. The administration documentation on [NJ ex order 26] indicated that the [NJ Exec Order] was administered at 6 PM. There were no corresponding [NJ Exec Order 26.4b1] results indicated on the eMAR.

A review of the resident's [NJ ex order 26] [NJ Exec Order 26.4b1] results collected on [NJ ex order 26] indicated that the [NJ ex order 26.4b1] [redacted].

On 3/7/24 at 1:21 PM, the survey team met with th [US FOIA (b)(6) redacted] and [US FOIA (b)(6) redacted] The surveyor requested that the [US FOIA (b)] provide documentation of the [NJ Exec Order 26.4b1] results and nurses notes that correlated with the administration documentation of [NJ ex order 26.4b1 redacted]

On 3/13/24 at 12:50 PM, the survey team met with the [US FOIA (b)(6)] and [US FOIA (b)] The [US FOIA (b)] stated that

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F 755	Continued From page 11	F 755		

the NJ Exec Order 26.4b1 would usually be obtained the day before or day of the date of administration of NJ ex order 26 to fulfill the PO. The US FOIA (b) explained that on NJ ex order 26 there were NJ Exec Orde results obtained because Resident #21 NJ ex order 26.4b1 o there were no results to base whether the NJ ex order 26 should have been administered according to the PO. The US FOIA (b) added that she would have expected the nurse to call the physician for follow up orders. The US FOIA (b) also explained that the NJ Exec results for the administration of NJ ex order 26.4b1 were obtained on NJ ex order 26.4 but were not posted until NJ ex order 26.4b1 The US FOIA (b) added that she would have expected the nurse to call the physician and move the PO to NJ Exec O for administration. The US FOIA (b) further explained that the US FOIA had indicated in the EPN that the NJ Exec Order was held for a NJ Exec O because the US FOIA was using the NJ Exec O results from NJ ex order 26.4b. The US FOIA (b) acknowledged that the US FOIA had made an error. The US FOIA (b) also stated that there were NJ Exec Order 26 results that were NJ ex order 26.4b1 and NJ ex orde which indicated according to the PO that the NJ Exec Order should be administered. The US FOIA (b) also stated that according to the EPN the US FOIA had documented that there was no supply of the medication and therefore the medication was not administered. The US FOIA (b) added that she would have expected the US FOIA to follow up with the pharmacy to obtain the NJ Exec Order or call the physician for follow up orders. The US FOIA (b) was unable to speak to what the issue was with obtaining the NJ Exec Order from the provider pharmacy because the US FOIA had not documented the reason the medication was not available or followed up with the pharmacy or gave a report to the next shift to follow up. The US FOIA (b) stated that the US FOIA was the same US FOIA for all the dates in February

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315479	A. BUILDING _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	68 PASSAIC AVENUE LIVINGSTON, NJ 07039

(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
F 755	Continued From page 12 for the [NJ Exec Order] administration. The [US FOIA (b)] acknowledged that the [US FOIA] had not followed proper procedure for making sure the [NJ Ex] results were obtained according to the PO and ensuring the [NJ Exec Order] was administered according to the PO. In addition, the [US FOIA (b)] stated that on [NJ ex order 26.4] there was an inservice explaining the procedure to follow when a medication was not available that the [US FOIA] had attended but had not followed the procedure. The US FOIA (b)(6) stated that moving forward any medication that was not available from the provider pharmacy was to be reported by the nurses to administration so that additional follow up would be able to be completed to ensure either obtaining the medication or follow up by a physician. A review of the current facility policy for Administering Medications with an edited date of 5/21/19 provided by the [US FOIA (b)] reflected that "Medications are administered in a safe and timely manner, and as prescribed." The Policy Interpretation and Implementation included; "Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions." In addition, "Medications are administered in accordance with prescriber orders, including time frame." Also, "As required or indicated for a medication, the individual administering the medication records in the resident's medical record: .....Any results achieved and when those results were observed." NJAC 8:39-11.2(b), 29.2 (a)(d), 29.3(5)	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F 759		3/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315479	A. BUILDING _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	68 PASSAIC AVENUE LIVINGSTON, NJ 07039

(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
F 759	Continued From page 13 §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication administration observation on 3/6/24, the surveyor observed four (4) nurses administer medications to six (6) residents. There were 25 opportunities, and three (3) errors were observed which calculated to a medication administration error rate of 12%. This deficient practice was identified for two (2) of six (6) residents, (Resident #26 and an unsampled resident), that were administered medications by two (2) of four (4) nurses that were observed. The deficient practice was evidenced by the following: 1. On 3/6/24 at 7:56 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse #1 (LPN #1) preparing to administer medications to an unsampled resident which included NJ ex order 26.4b1 [redacted] The surveyor observed LPN #1 administer the medication to the resident and observed there was no meal tray at the resident's bedside. At 8:04 AM, the surveyor observed LPN #1 preparing to administer remaining medications with an administration time of 9:00 AM to the same unsampled resident. Upon re-entering the	F 759	NJ ex order 26.4b1 order for Resident 26 was clarified with the MD for a NJ ex order 26.4b [redacted] and EMAR updated to reflect NJ ex order 26.4b1 order for Resident 26 was reviewed with physician and NJ ex order 26.4b1 NJ Exec Order 26.4b1 were removed from the medication cart and NJ Exec Order 26.4b1 patches were stocked in the cart. Resident 26 had NJ Ex NJ Exec Order 26.4b1 related to this practice. All residents have the potential to be affected by this deficient practice. LPN 1 was re-educated on administration and action of Glipizide, to be administered according to physicians' orders 30 minutes prior to a meal. LPN 2 was re-educated on the 5 rights of medication administration including right dose. LPN 2 was re-educated to clarify orders to ensure medication matches the physicians' order. The Director of Nursing completed an audit of all residents on Glipizide to ensure the orders reflect proper administration of 30minutes before a meal. The Director of Nursing conducted an audit of all residents with orders for Lidocaine patches to ensure the medication matches the physicians' order. In-service education provided by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315479	A. BUILDING _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	68 PASSAIC AVENUE LIVINGSTON, NJ 07039

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F 759	Continued From page 14 resident's room in the presence of LPN #1, the surveyor observed the resident with a meal tray and consuming food. The surveyor reviewed the electronic Medication Administration Record (eMAR) which reflected the physician's order as NJ ex order 26.4b1 [redacted] with an administration time of 7:00 AM. The surveyor asked LPN #1 if the NJ ex order 26.4b1 was given thirty (30) minutes before the residents AM meal as reflected in the physician's order. LPN #1 stated the NJ ex order 26.4b1 was not given thirty (30) minutes before the meal as stated in the physician's order. 2. On 3/6/24 at 8:39 AM, during the medication administration observation, the surveyor observed LPN #2 preparing to administer medications to resident #26. The surveyor observed the resident's eMAR which reflected an order NJ ex order 26.4b1 [redacted]. The order did not indicate a strength or dosage. The surveyor observed LPN #2 prepare NJ ex order 26.4b1 [redacted] The surveyor asked LPN #2 how they knew that was the correct dose. LPN #2 stated that those were the standard ones the facility always uses. 3. The surveyor continued to observe LPN #2 prepare medications for Resident #26. The surveyor observed the resident's eMAR which reflected an order for NJ ex order 26.4b1 [redacted] The surveyor observed LPN #2 NJ ex order 26.4b [redacted]	F 759	Director of Nursing for all nurses on medication administration. Pharmacy Consultant will conduct on-going medication administration observations with nurses, on a monthly basis, to ensure all nurses have had this competency annually. Director of Nursing or designee will review monthly Pharmacy Consultant reports and ensure that all medication orders are entered properly indicating strength of the medication, on-going. Director of Nursing or designee will audit new physicians' orders for Glipizide weekly x 4 weeks and monthly x 3 months, with results provided to QAPI monthly x 3 months and quarterly x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315479	A. BUILDING _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	68 PASSAIC AVENUE LIVINGSTON, NJ 07039

(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
F 759	Continued From page 15	F 759		

NJ ex order 26.4b1 The surveyor asked LPN #2 if that was the correct item and strength. LPN #2 stated was since 4% plus 1% equals 5%.

The surveyor observed the packaging for the NJ Exec Order 26.4b1 which indicated active ingredients of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 . The surveyor asked LPN #2 if the NJ Exec Order 26.4b1 contained NJ Exec [redacted] LPN #2 stated the package label says it contains NJ Exec Order 26.4b1 .

The surveyor did not observe any NJ Exec Order 26.4b1 external patches present in the medication cart.

On 03/6/24 at 12:13 PM, the surveyor interviewed the US FOIA (b)(6)) by phone and asked if a NJ Exec Order 26.4b1 was equivalent to a NJ Exec Order 26.4b1 . The US FO stated they are not equivalent. They are different products. The surveyor asked the US FO what the appropriate administration timing for NJ Exec Order 26.4 would be in relation to meals. The US FO stated that NJ Exec Order 26.4 should be given at least 30 minutes before the meal.

The surveyor reviewed the medication information sheet for NJ Exec Order 26.4b1 . The information indicated NJ Exec Order 2 capsules are available in multiple strengths, including NJ Exec Order 26.4b1 . The information also indicated the daily dose can be from NJ Exec Order 26.4b1 per day.

The surveyor reviewed the packaging and ingredient list for NJ Exec Order 26.4b1 and the medication information sheet for NJ Exec Order 26.4b1 patch.
The surveyor observed the NJ Exec Order 26.4b1

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	315479	A. BUILDING _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	**68 PASSAIC AVENUE LIVINGSTON, NJ 07039**

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F 759	Continued From page 16 contains NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 as active ingredients, while NJ Exec Order 26.4b1 contains only NJ Exec Order 26.4b1 as the active ingredient. On 3/6/24 at 12:30 PM, the US FOIA (b)(6) provided the surveyor with the facility policy on Administering Medications, revised April 2019, edited 5/21/19. The policy indicated at line 4. "Medications are administered in accordance with prescriber orders, including any required time frame." It also indicated at line 7. "Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). And line 10. indicated "The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication." N.J.A.C 8:39-29.2 (d)	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	306301	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	68 PASSAIC AVENUE LIVINGSTON, NJ 07039

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the minimum direct care staff-to-resident ratios mandated by the State of New Jersey. Reference: NJ State requirement, Chapter 112, An Act Concerning Staffing Requirements for Nursing Homes and Supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing	S 560	Administrator, Director of Nursing, or designee will meet with the Staffing Coordinator daily to review the staffing for the following day. All residents have the potential to be affected by this deficient practice. LNHA, DON, and Staffing Coordinator will identify specific days of the week that pose a greater challenge for staffing and implement a plan to increase staffing on those specific days of the week. The plan includes incentives for current staff to pick up the extra shifts that require more staff, host a job fair to fill vacancies, offer sign-on bonuses for new hires, referral	3/29/24

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

Electronically Signed | 03/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	306301	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	68 PASSAIC AVENUE LIVINGSTON, NJ 07039

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S 560	Continued From page 1 requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift. (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of the resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff	S 560	bonuses for employees referring new staff, expedite the onboarding process for new hires, and work with CNA school to hire new graduates. Staffing will be reviewed daily by the LNHA and DON to ensure staffing is according to regulatory ratio. DON or designee will monitor call outs and staffing ratios weekly until requirement is met. Staffing ratio will be reviewed on a monthly basis with the Quality Assurance Committee for a period of 3 months, at which time it will be determined if continued monitoring is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	306301	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	68 PASSAIC AVENUE LIVINGSTON, NJ 07039

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S 560	Continued From page 2	S 560		

members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.

(3) All computations shall be based on the midnight census for the day on which the shift begins.

d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ...

A review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Reports for two weeks of staffing for three distinct time periods received from facility administration during the 3/14/2024 Standard survey revealed deficient staffing ratios as evidenced by the following:

During the two weeks of staffing before the Standard Survey from 2/18/2024 to 3/2/2024, the facility was deficient in CNA staffing for residents on 1 of 14-day shifts and deficient in CNAs to total staff on 1 of 14 evening shifts as follows:

- 02/23/24 had 5.5 CNAs to 12.5 total staff on the evening shift, which required at least 6 CNAs.
- 03/02/24 had 5 CNAs for 56 residents on the day shift, which required at least 7 CNAs.

The surveyor reviewed the facility policy and procedure titled "Staffing, Sufficient, and Competent Nursing," revised in August 2022,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	306301	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	**68 PASSAIC AVENUE LIVINGSTON, NJ 07039**

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S 560	Continued From page 3 provided by the Licensed Nursing Home Administrator (LNHA). "Policy Interpretation and Implementation" under "Sufficient Staff 8. Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing." On 3/14/24 at 11:07 AM, the survey team discussed with the Licensed Nursing Home Administrator and Director of Nursing that some of the shifts fell below the State required minimum staffing ratios.	S 560		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315479		3/30/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	68 PASSAIC AVENUE LIVINGSTON, NJ 07039

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0640 Reg. # 483.20(f)(1)-(4) LSC	Correction Completed 03/29/2024	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 03/29/2024	ID Prefix F0759 Reg. # 483.45(f)(1) LSC	Correction Completed 03/29/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
3/14/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
306301 Y1	A. Building B. Wing Y2	3/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	68 PASSAIC AVENUE LIVINGSTON, NJ 07039

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/29/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
3/14/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315479	A. BUILDING **01** B. WING _____	**03/14/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	**68 PASSAIC AVENUE** **LIVINGSTON, NJ 07039**

(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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 03/07/24. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 03/07/24 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Careone at Livingston is a one-story building that was built in 2002. It is composed of Type II protected construction. The facility is divided into four - smoke zones. The generator does approximately 50 % of the building per the Maintenance Director. The current occupied beds are 62 of 72.	K 000		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511		3/23/24

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

Electronically Signed | 03/27/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315479	A. BUILDING **01** B. WING _____	**03/14/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	**68 PASSAIC AVENUE** **LIVINGSTON, NJ 07039**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure that Nonmetallic Sheathed Cable was concealed within walls, floors, or ceilings that provided a thermal barrier of material that has at least a 15-minute finish rating as identified in listings of fire-rated assemblies in accordance with NFPA 70 National Electrical Code (2011 Edition) Article 334.10 (3) (5). This deficient practice had the potential to affect all 62 residents who resided at the facility. Findings include: An observation on 03/07/24 at 12:49 PM revealed Nonmetallic Sheathed Cable was exposed in the mechanical room coming out of the electrical panels and going to a light fixture on the ceiling and not protected by a 15-minute fire rating. During an interview at the time of the observation, the US FOIA (b)(6) verified the Nonmetallic Sheathed Cable was not protected by a 15-minute fire rating. NJAC 8:39-31.2(e) NFPA 70	K 511	Supplies have been purchased to construct a thermal barrier that covers the nonmetallic sheathed cable. All residents have the potential to be affected by this practice. Thermal wall barrier has been constructed to contain the nonmetallic sheathed cable by a 15-minute fire rating. Now that thermal barrier has been put in place, pictures will be shared with the Quality Assurance Committee for review. Maintenance Director or designee will monitor the mechanical room on a weekly basis to ensure the thermal barrier is in good condition on a continuous basis. Weekly review data will be shared with the Quality Assurance Committee on a monthly basis for a period of 3 months, at which time it will be determined if continued monitoring is required.	
K 524 SS=F	HVAC - Direct-Vent Gas Fireplaces CFR(s): NFPA 101 Direct-Vent Gas Fireplaces Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing	K 524		5/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315479	A. BUILDING **01** B. WING _____	**03/14/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	**68 PASSAIC AVENUE** **LIVINGSTON, NJ 07039**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 524	Continued From page 2 patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the carbon monoxide detectors located at Direct-Vent Gas Fireplaces were electrically supervised in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.5.2.3.(2)(f). This deficient practice had the potential to affect all 62 residents who resided at the facility. Findings include: An observation on 03/07/24 at 12:54 PM revealed that the carbon monoxide detectors for the Direct-Vent Gas Fireplaces were battery operated and not electrically supervised to the fire alarm system. During an interview at the time of the observations, the US FOIA (b)(6) confirmed that the carbon monoxide detectors were not electrically supervised. NJAC 8:39-31.2(e)	K 524	The fireplace in the living room area was immediately taken out of service. All residents have the potential to be affected by the deficient practice. The fireplace was immediately taken out of service with gas line shut off. The fire panel system is in the process of being upgraded. Vendor retained to upgrade the system. Fire panel system requires upgrading in order to hard-wire the carbon monoxide detector to be electrically supervised. Permit with blueprints will be submitted to the Township of Livingston for approval on 4/10/24. Once approval is received, vendor will install new fire panel system including a hard-wired carbon monoxide detector. The Director of Maintenance and LNHA will communicate weekly with the fire alarm vendor to follow up on the status of the permit and thereafter, with the progress of the installation to ensure timely completion of new fire panel and hard-wiring of the carbon monoxide detector. Once new fire panel is installed and carbon monoxide detector is hard-wired, this would be a permanent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315479	A. BUILDING **01** B. WING _____	**03/14/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	**68 PASSAIC AVENUE** **LIVINGSTON, NJ 07039**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 524	Continued From page 3	K 524	solution that would prevent reoccurrence. Maintenance Director will ensure that the carbon monoxide detectors are inspected during the semi-annual fire alarm inspection and that reports are provided to the facility. Fire alarm inspection reports will be shared with the Quality Assurance Committee upon their completion every 6 months for a period of 1 year, at which time it will be determined if further monitoring is needed.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315479	A. Building 01 - CARE ONE AT LIVINGSTON B. Wing	5/28/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	68 PASSAIC AVENUE LIVINGSTON, NJ 07039

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0511	Correction Completed 03/23/2024	ID Prefix Reg. # NFPA 101 LSC K0524	Correction Completed 05/28/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/14/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO