STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. BUILDING _____ B. WING _____	C 02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET 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 #: NJ00169866, NJ00165595 Census: 123 Sample Size: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		3/31/24

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

Electronically Signed | 03/22/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. BUILDING _____ B. WING _____	C 02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET 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 656	Continued From page 1 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: C# NJ00169866 Based on interview, medical records (MR) review, and review of pertinent facility documents on 02/08/24 and 02/12/24, it was determined that the facility failed to complete the residents care plan (CP) that was initiated on [redacted] for a Resident who was at risk [redacted] for 1 of 4 residents (Resident #2). The deficient practice was evidenced by the following: According to the Admission Record (AR), Resident #2 was admitted with diagnoses which included but were not limited to: [redacted]	F 656	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: F656 Development/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) There was one resident identified in the Statement of Deficiencies (SOD) as being affected by this practice. This resident is no longer a patient at the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. BUILDING _____ B. WING _____	C 02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET 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 656	Continued From page 2 NJ EX Order: 264b1. The Minimum Data Set (MDS), an assessment tool dated [redacted] revealed Resident #2 had a Brief Interview for Mental Status (BIMS) of [redacted] which indicated cognition was NJ EX Order: 264b1 and the resident needed help in Activities of Daily Living (ADLs). Review of the progress notes (PN), dated [redacted] at 2:21 p.m., documented by Licensed Practical Nurse (LPN #1), indicated "Patient [Resident #2] received walking [redacted]. Medication given as prescribed. Eat [redacted] of breakfast. At 11:30 [a.m.] patient had a [redacted] while walking on the hallway. [redacted] was witnessed. Doctor notified; family notified. Dr. ordered to send the patient out to the ER. for [redacted] A Care Plan (CP), initiated on [redacted] and revised on [redacted] did not reflect interventions related to the Resident's [redacted] on [redacted]. During the interview with the ADON on 02/08/24 at 3:23 p.m., the ADON stated that when a [redacted] occurred, the Interdisciplinary Team (IDT), DON, ADON, UM, Social Service, and the Director of Rehab, would review the incident report and would revise and or update the CP on the day it was being reviewed. The ADON was unable to explain why Resident #2's CP did not include interventions to reflect the Resident's [redacted] on [redacted]. A review of the facility's policy titled "Care Plans, Comprehensive Person-Centered" last updated 5/2023, under "Policy Interpretation and Implementation 9. Care plan interventions are	F 656	All residents have the potential to be affected by the practice identified in the SOD. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. A new system will be put in place by 3/25/24 whereas the interdisciplinary team (IDT) will implement a care plan review program to ensure care plans are appropriate for residents who [redacted] or are at risk of [redacted] The interdisciplinary team will meet post fall and determine appropriate interventions as clinically indicated. Plan of Care will be updated accordingly. The IDT meets 4-5 days a week to reviews [redacted] On weekends, the facility supervisor or designee will identify risk and update care plans accordingly. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. In service education will be provided by Director of Nursing or designee by 3/27/24 to nursing staff on care plan policy, including care planning after each [redacted] and when a resident is identified as having a risk for a fall. Administrator and Director of Nursing will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. BUILDING _____ B. WING _____	C 02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET 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 656	Continued From page 3 chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible, interventions address the underlying source (s) of the problem areas, not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay." N.J.A.C: 8:39-11.2 (e)2 (i)	F 656	review [redacted] in risk management to ensure care plans updated after a [redacted] and interventions appropriate after a [redacted] Care plans will be updated after every [redacted], as needed, and minimally quarterly if no changes occur. Director of Nursing or designee will review care plans for new admissions to ensure they are completed and will do a QAPI for March and April to ensure care plans are completed timely and accurately. The Director of Nursing will audit the care plans for 10 residents weekly for 4 weeks and then Monthly to ensure 100% compliance. Documentation. - The results of the audits will be reviewed during the monthly QAPI Committee meeting. - The QAPI Committee will make recommendations as indicated based upon the results of the audits - The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. Include dates when corrective action will be completed. Completion Date 3/31/24 and audit monthly x 3 months or until the QAPI committee deems appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH07001	A. BUILDING: _____ B. WING _____	C 02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET 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) COMPLETE DATE
S 000	Initial Comments Complaint #: NJ00169866, NJ165595 The facility was 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: Complaint #: NJ00169866, NJ 00165595 Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 21 of 28 day shifts. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. S560 No residents were identified as having been affected. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected.	3/31/24

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

Electronically Signed | 03/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH07001	A. BUILDING: _____ B. WING _____	C 02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET 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) COMPLETE DATE
S 560	Continued From page 1 nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every ten residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties, and one direct care staff member to every fourteen residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for the weeks of 12/02/2023 to 12/16/2023, and 01/21/2024 to 02/03/2024. The facility was deficient in CNA staffing for residents on 21 of 28 day shifts as follows: -12/03/23 had 14 CNAs for 120 residents on the day shift, required at least 15 CNAs. -12/04/23 had 14 CNAs for 120 residents on the day shift, required at least 15 CNAs. -12/05/23 had 14 CNAs for 120 residents on the day shift, required at least 15 CNAs. -12/06/23 had 14 CNAs for 120 residents on the day shift, required at least 15 CNAs. -12/07/23 had 14 CNAs for 120 residents on the day shift, required at least 15 CNAs. -12/08/23 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs. -12/09/23 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs. -12/10/23 had 13 CNAs for 118 residents on the	S 560	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Director of Nursing, Staffing Coordinator and Administrator will meet daily during the week to review recruitment efforts, staffing for next day, and staffing for upcoming week. Trends identified from these meeting will be presented during monthly QAPI meeting. The facility has implemented a multifaceted approach for recruitment and retention of employees, which includes increased utilization of PRN/Per diem staff (Staff hired without any set hours, usually staff who have another job and pickup extra shifts when the need arises), Multimedia advertisements, Partnership with schools, Pick-up shift bonuses, Text message campaigns. Flyers placed around the buildings and on social media. The facility has hired a recruitment company to do paid campaigns with Indeed, and other social media platforms to recruit nursing staff. Daily update emails and weekly meetings help to identify trends in hiring and review all new hires and where candidates stand in the hiring process. Targeted advertising in place to attract licensed nurses and aides. Employee engagement is led by management team/department heads to facilitate celebrations, staff recognition, fun contests, and staff giveaways.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH07001	A. BUILDING: _____ B. WING _____	C 02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET 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) COMPLETE DATE
S 560	Continued From page 2 day shift, required at least 15 CNAs. -12/14/23 had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs. -12/16/23 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs. -01/22/24 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. -01/23/24 had 14 CNAs for 122 residents on the day shift, required at least 15 CNAs. -01/26/24 had 14 CNAs for 122 residents on the day shift, required at least 15 CNAs. -01/27/24 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. -01/28/24 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. -01/29/24 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. -01/30/24 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. -01/31/24 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs. -02/01/24 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs. -02/02/24 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs. -02/03/24 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs.	S 560	Referral bonus in place for any staff who refer a friend who gets hired, bonus amounts range from $500-$1000. Sign on bonuses in place to attract aides and nurses in the amount of $2500-$10,000. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Administrator/designee will review the minutes from monthly resident council meetings x 3 months to determine whether there are any concerns regarding care and services. Staffing coordinator will present call out histories of staff to DON weekly x 4 weeks. The results of the staffing audit will be reported to the facility QAPI Committee x 3 months to determine if sufficient compliance has been met. Based on the results of the audit the QAPI committee will determine continued need for the audit.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315526 Y1	A. Building B. Wing Y2	4/1/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVINGSTON POST ACUTE CARE	348 E CEDAR STREET 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 F0656	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/31/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
2/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO