STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	1 SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 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
F 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC, on behalf of the New Jersey Department of Health (NJDOH). Complaint #: NJ00167004, NJ00169239, NJ00174428, and NJ00175733. Survey Dates: 09/17/24 through 09/20/24 Survey Census: 72 Sample Size: 22 Supplemental Residents: 0 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 RECERTIFCATION AND COMPLAINT VISIT.	F 000		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the	F 693		9/25/24

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

Electronically Signed | 10/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	1 SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 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
F 693	Continued From page 1 resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure appropriate care of a NJ Ex Order 26.4(b)(1)) during NJ Ex Order 26.4(b)(1) and medication administration for one resident (Resident (R) 178) of one resident reviewed during medication administration with NJ Ex Order 2. Specifically, Licensed Practical Nurse (LPN) 1 administered NJ Ex Order 2 medications via NJ Ex Order 26.4(b)(1) rather than by NJ Ex Order 26 administration and failed to check for proper NJ Ex Order 26.4(b)(1). This failure increases the risk for NJ Ex Order 26.4 NJ Ex Order 26.4(b) or NJ Ex Order 26.4(b)(1) Findings include: Review of the facility's policy titled "Enteral Nutrition" revised 11/2018 did not include medication administration, but did include " ...Risk of aspiration is assessed by the nurse and provider and addressed in the individual care plan. Risk of aspiration may be affected by: ...failure to confirm placement of the feeding tube prior to initiating the feeding ..." Review of the facility's policy titled "Administering Medications through an Enteral Tube" revised 11/2018 stated to prepare the resident by " ...verify placement of feeding tube ...dilute	F 693	What corrective action will be accomplished for those residents affected by the deficient practice Nurse was removed from assignment and in-service on appropriate infection control specifically the cleaning of glucometer when obtaining a fingerstick. How will the facility identify other residents having the potential to be affected by the same deficient practice? Any resident has the potential to be affected What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The facility conducted an audit by DON, and/or Infection Preventionist on proper infection control specifically cleaning of glucometer all were in-service with return demonstration. All new nurses will also complete infection control specifically use of glucometer	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	1 SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 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
F 693	Continued From page 2 medication: a. Remove plunger from syringe ...11. Reattach syringe (without plunger) to the end of the tubing. 12. Administer medication by gravity flow: a. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion ..." Review of LPN1's Annual Competency training, provided by the facility, dated NJ Ex Order 26.4b1 included "Gastrostomy (g-tube) Feedings" which included checking the placement of the tube and hanging the prescribed feeding. Review of a document provided by the facility titled "Attendance Record," dated NJ Ex Order 26.4b1 for an in-service related to "Peg Tube [percutaneous endoscopic gastrostomy which is similar to a g-tube and requires the same in regard to checking of placement and administration of medications]" included LPN1's signature. The document indicated LPN1 was educated verbally and performed return skill demonstrations related to peg tubes. Review of R178's undated "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab indicated the resident was admitted to the facility on NJ Ex Order 26.4(b) with diagnoses which included NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , NJ Ex Order , and NJ Ex Order 26.4(b)(1). Review of R178's admission "Minimum Data Set (MDS)" with an assessment reference date (ARD) of NJ Ex Order 26.4(b) and located in the resident's EMR under the "MDS" tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15 which indicated R178 was NJ Ex Order 26.4(b)(1). The	F 693	competencies on their orientation check list. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The DON and/or Designee will perform random audits to ensure goof infection control with glucometer use residents when taking finger sticks. 5 staff weekly for 4 weeks, then 10 staff per month x 3 months, then 15 staff per quarter x 1 year. The results of the audits will be forwarded to the facility Administrator and QAA Committee for further review and recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 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
F 693	Continued From page 3	F 693		

MDS also revealed the facility assessed that R178 received NJ Ex Order 26.4(via a NJ Ex Order 26.4(b)(1) which provided greater than NJ Ex Order 26.4(b)(1) [redacted]

Review of R178's "Care Plan" located in the resident's EMR under the "Care Plan" tab included NJ Ex Order 26.4(b)(1) and administration of medications as ordered by the physician dated NJ Ex Order 26.4(b) .

Review of R178's "Order Summary Report" located in the EMR under the "Orders" tab included an order dated NJ Ex Order 26.4(b) for NJ Ex Order 26 [redacted] every four hours, check NJ Ex Order 26.4(b)(1) before initiation of NJ Ex Order 26.4 or medication administration. Continued review revealed an order dated NJ Ex Order 26.4(b) for NJ Ex Order 26.4(b)(1) [redacted], give one packet via NJ Ex Order 26 two times a day for NJ Ex Order 26.4(b)(1) [redacted] and NJ Ex Order 26.4(b)(1) [redacted], give NJ Ex Order 26.4(b)(1) two times a day for NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) [redacted] of water before and after administration of medication pass.

During an observation and interview on 09/19/24 at 3:58 PM revealed LPN1 prepared and administered R178 NJ Ex Order 26.4(b)(1) at NJ Ex Order 26.4(b)(1) . LPN1 did not check NJ Ex Order 26.4(b)(1) and used NJ Ex Order 26.4(b)(1) to administer NJ Ex [redacted] prior to administration of the NJ Ex Order 26.4(b)(1) . R178 immediately asked for the NJ Ex Order 26.4(b)(1) and complained of NJ Ex Order 26.4 [redacted]

During an observation on 09/19/24 at 5:14 PM LPN1 prepared NJ Ex Order 26.4(b)(1) . LPN1 could not prepare the ordered NJ Ex Order 26.4(b)(1) [redacted] packet because the medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	1 SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 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
F 693	Continued From page 4	F 693		

was not available for R178. LPN1 verified the ordered NJ Ex Order 26.4(b)(1) with Unit Manager (UM) 1. The physician was notified, and the order was changed to NJ Ex Order 26.4(b)(1) , give NJ Ex Order 26.4(b)(1) via NJ Ex Order 26.4(b)(1) . LPN1 paused the NJ Ex Order 26.4(b)(1), checked for placement of the NJ Ex Order 26.4(b)(1) while listening with the NJ Ex Order 26.4(b)(1) LPN1 then checked for NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1). Continued observation revealed LPN1 then administered NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4 , administered NJ Ex Order 26.4(b)(1) , then NJ Ex Order 26.4(b)(1) prior to reconnecting the NJ Ex Order 26.4(b)(1).

During an interview on 09/19/24 at 6:33 PM, UM1 stated it was her expectation nurses check for placement prior to NJ Ex Order 26.4(b)(1) and medication administration via NJ Ex Order 26.4(Additionally, unless ordered by the physician, medications and NJ Ex Order 26 should be administered via NJ Ex Order 26.4(b)(1) .

During an interview on 09/19/24 at 7:00 PM, LPN1 confirmed she did not check for placement of R178's NJ Ex Order 2 during NJ Ex Order 26.4(b)(1) administration at 4:58 PM because the resident's NJ Ex Order 26.4(would have been empty. When asked how she knew the NJ Ex Order 26.4(b)(1), LPN1 did not answer. LPN1 then stated she was in the habit of checking placement prior to medication administration. LPN1 confirmed she used the NJ Ex Order 26.4(b)(1) to administer medications instead of NJ Ex Order 26 because with the type of NJ Ex Orc that R178 had, she had to do that in order for the medications to go through the NJ Ex Order 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	1 SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 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
F 693	Continued From page 5 During an interview on 09/20/24 at 7:44 PM, the U.S. FOIA (b) (6)) stated she was aware of the concerns and stated it was her expectation for nurses to confirm NJ Ex Order 26.4(b)(1) by listening with a NJ Ex Order 26.4(b)(1) listen for the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1). The U.S. FOIA also stated some doctors were very specific on NJ Ex Order 26.4(b)(1) and that would have been included in the order if the nurse should hold the NJ Ex Order 26.4(b)(1) based on the NJ Ex Order 26.4(b)(1). Medication administered via NJ Ex Order 26.4(b)(1) should be done via NJ Ex Order 26.4(b)(1) however, because R178's NJ Ex Order 26.4(b)(1) was special, the nurses had to do it NJ Ex Order 26.4(b)(1). The U.S. FOIA further stated the nurses had to administer medications via NJ Ex Order 26.4(b)(1). After this surveyor notified UM1 of the concern on NJ Ex Order 26.4(b)(1) of R178's NJ Ex Order 26.4(b)(1) the facility obtained an order for NJ Ex Order 26.4(b)(1) administration.	F 693		
F 880 SS=D	NJAC 8:39-27.1(a) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		9/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	1 SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 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
F 880	Continued From page 6 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	1 SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 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
F 880	Continued From page 7 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure proper cleaning and disinfecting of multi-use NJ Ex Order 26.4(b)(1) prior to NJ Ex Order 26.4(b)(1) for one resident (Resident (R) 3) of two residents reviewed for NJ Ex Order 26.4(b)(1) monitoring. This failure increased the risk for NJ Ex Order 26.4(b) and transmission of NJ Ex Order 26.4(b)(1). Findings include: Review of the facility's policy titled "Obtaining a Fingerstick Glucose Level," revised 10/2011 revealed, " ... Steps in the procedure ...Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses ...If alcohol is used to clean the fingertip, allow it to dry completely because the alcohol may alter the reading ...Obtain a blood sample by using a sterile lancet ...Discard the first drop of blood if alcohol is used to clean the fingertips because alcohol may alter the results ..." Review of undated glucometer "Cleaning and Disinfecting Procedures for the Meter" provided	F 880	What corrective action will be accomplished for those residents affected by the deficient practice? Nurse was removed from assignment and in-service on appropriate infection control specifically the cleaning of glucometer when obtaining a fingerstick. How will the facility identify other residents having the potential to be affected by the same deficient practice? Any resident has the potential to be affected What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The facility conducted an audit by DON, and/or Infection Preventionist on proper infection control specifically cleaning of glucometer all were in-service with return demonstration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	1 SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 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
F 880	Continued From page 8 by the facility stated, "The EVENCARE ProView Meter should be cleaned and disinfected between each patient ...Whenever your glucose meter is dirty, clean the outside of the meter with a new CaviWipes (effective surface disinfectant, effective against TB in 3 minutes, and HIV-1, HCV, HBV, and MRSA in 2 minutes) towelette or an EPA-registered disinfecting wipe ...Disinfection Instructions: The meter must be disinfected between patient uses by wiping it with a CaviWipe towelette or EPA-registered disinfecting wipe in between tests and cleaned prior to disinfecting. The disinfection process reduces the risk of transmitting infectious diseases if it is performed properly ..." Review of Licensed Practical Nurse (LPN) 2's Annual Competency training provided by the facility and dated NJ Ex Order 26.4(b) included NJ Ex Order 26.4(b)(1) testing and NJ Ex Order 26.4(b)(1) cleaning. Review of R33's undated "Admission Record" located in the resident's Electronic Medical Record (EMR) under the "Profile" tab revealed he was admitted to the facility on NJ Ex Order 26.4(b) with diagnoses which included NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Review of R33's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Ex Order 26.4(b) and located in the EMR under the "MDS" tab, revealed the MDS documented R33 had NJ Ex Order 26.4(b)(1), had orders for NJ Ex Order 26 and received NJ Ex Order 26 for seven days in the review period. Review of R33's "Order Summary Report" located in the EMR under the Orders" tab included an	F 880	All new nurses will also complete infection control specifically use of glucometer competencies on their orientation check list. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The DON and/or Designee will perform random audits to ensure goof infection control with glucometer use residents when taking finger sticks. 5 staff weekly for 4 weeks, then 10 staff per month x 3 months, then 15 staff per quarter x 1 year. The results of the audits will be forwarded to the facility Administrator and QAA Committee for further review and recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 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
F 880	Continued From page 9 order dated [redacted] of [redacted] as per sliding scale (if reading from [redacted] was): [redacted]; [redacted]; [redacted], [redacted] with meals for [redacted]. During an observation and interview on 09/19/24 at 5:00 PM, LPN2 prepared to check R33's [redacted] by performing hand hygiene, donned gloves, cleansed R33's [redacted] with an alcohol swab. The LPN then used [redacted] to [redacted] the resident's [redacted] obtained [redacted], and applied it to the [redacted]; however, LPN2 did not [redacted] the [redacted] prior to applying the [redacted]. LPN2 stated after she completed [redacted] that she had forgotten to [redacted], and forgot to [redacted] and let it dry prior to using for R33 but should have. During an interview on 09/20/24 at 3:38 PM, Unit Manager (UM) 2 provided a copy of "Cleaning and Disinfecting Procedures for [redacted]" and confirmed the manufacturer's instructions were the expectation of the facility related to [redacted] between resident usage. During an interview on 09/20/24 at 7:44 PM, the [redacted]) stated it was her expectation nurses disinfect [redacted] before and after use for each resident due to risk for infection and transmission of [redacted]. NJAC 8:39-19.4	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH14002	A. BUILDING: _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	1 SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 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) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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 review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: 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 nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were	S 560	What corrective action will be accomplished for those residents affected by the deficient practice? The facility leadership team has met on an ongoing basis and continue to identify staffing challenges and areas of improvement for licensed and certified staffing needs How will the facility identify other residents having the potential to be affected by the same deficient practice? Any resident has the potential to be affected	9/25/24

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

Electronically Signed | 10/03/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH14002	A. BUILDING: _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	1 SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 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) COMPLETE DATE
S 560	Continued From page 1 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 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and 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 CNA and perform CNA duties. The facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -09/03/24 had 8 CNAs for 69 residents on the day shift, required at least 9 CNAs. -09/05/24 had 8 CNAs for 69 residents on the day shift, required at least 9 CNAs. -09/11/24 had 8 CNAs for 69 residents on the day shift, required at least 9 CNAs.	S 560	What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The facility has implemented a significant above market rate for nurses and certified nursing assistants The facility has implemented a referral bonus for employees referring staff where appropriate The facility has implemented an expedited onboarding process to new hires The facility will use agency staff as needed to meet staffing needs How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The DON and/or Designee meets with staffing coordinator daily to review facility census, call outs if any, and staffing needs The DON and/or Designee will monitor call outs and staffing ratios weekly until the requirement is met The results of the audits will be forwarded to the facility Administrator and QAA Committee for further review and recommendations as 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)
315529	A. Building B. Wing	11/8/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	1 SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 07936

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 F0693 Reg. # 483.25(g)(4)(5) LSC	Correction Completed 09/25/2024	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 09/25/2024	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

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	
9/20/2024	☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
NH14002		11/8/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	1 SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 07936

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 09/25/2024	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
9/20/2024

☐ 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
	315529	A. BUILDING **01** B. WING _____	**09/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE** **EAST HANOVER, NJ 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
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 09/18/24. 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, Health Facility Survey and Field Operations on 09/18/24 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 compartments. The natural gas generator powers 100% of the building. The facility has a complete automatic sprinkler system. The number of occupied beds was 71 out of 86.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	K 291	What corrective action will be	10/3/24

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

Electronically Signed | 10/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING **01** B. WING _____	**09/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE** **EAST HANOVER, NJ 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
K 291	Continued From page 1 failed to ensure emergency lighting was tested in accordance with NFPA 101 (2012 Edition) Section 7.3. This deficient practice had the potential to affect all 71 residents and was evidenced by the following: A review of the facility's records revealed monthly testing of the emergency lighting was not conducted. An annual test of the emergency lighting was conducted on 07/18/24. During an interview on 09/18/24 at 4:00 PM, the U.S. FOIA (b) (6) confirmed that documentation of the monthly test of the emergency lighting could not be located. NJAC 8:39-31.1(c), 31.2(e)	K 291	accomplished for those residents affected by the deficient practice? Monthly testing for emergency lighting log was created for monthly emergency lighting testing How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents and staff have the potential to be affected by the deficient practice What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Maintenance Director and/or their designee will ensure monthly emergency lighting testing is completed using monthly emergency lighting log How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Maintenance Department will monitor for 6 months using the monthly emergency lighting log audit tool to report to Quality Assurance Performance Improvement Committee. Maintenance Director will present findings and they will be reviewed quarterly at the QAPI meetings for compliance.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321		9/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING **01** B. WING _____	**09/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE** **EAST HANOVER, NJ 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
K 321	Continued From page 2 Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to separate hazardous areas from other parts of the facility in accordance with NFPA 101 Life Safety Code (2012 Edition), Section 8.4. This deficient practice had the potential to affect staff and no residents. Findings include:	K 321	What corrective action will be accomplished for those residents affected by the deficient practice? Maintenance Director purchased and installed a door closure on the kitchen dry storage door on 9/26/2024. See attached picture. In addition, the unsealed overcut	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING **01** B. WING _____	**09/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE** **EAST HANOVER, NJ 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
K 321	Continued From page 3 Observation on 09/18//24 at 3:45 PM of the Dry Storage Room, located inside the Kitchen, revealed a self-closing device was not installed on the door. The kitchen was provided with non-latching doors required for protecting a hazardous area. This resulted in the storage area being within a non-hazardous area requiring a self-closing door. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the finding and revealed the facility was unaware the door was missing a self-closing device. An observation on 09/18/24 at 3:53 PM of the Elevator Machine Room revealed an unsealed two inch overcut around a pipe penetration in the center of the wall. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the finding and revealed the facility was unaware of the unsealed overcut in the wall. NJAC 8:39-31.2(e)	K 321	around the pipe in the elevator machine room was sealed with Fire Stop Caulking. Please see attached picture. How will the facility identify other residents having the potential to be affected by the same deficient practice? The deficient practice was not in a resident care area but could affect the staff. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The U.S. FOIA (b) (6) was educated by the Administrator and in-serviced the Maintenance Team. The Maintenance Director and respective team members have updated the hazard and fire door audit to include the kitchen dry storage door which will be inspected annually. The elevator machine room will be inspected monthly to ensure there are no overcut areas around pipes. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The new door closure that was installed on the kitchen dry storage door will be tested and monitored weekly for the next 3 months, and annually thereafter. The elevator machine room will be inspected monthly to ensure all pipes are sealed and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING **01** B. WING _____	**09/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE** **EAST HANOVER, NJ 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
K 321	Continued From page 4	K 321	compliant. These inspections will be inspected monthly for the next three months and annually thereafter. There will be a QAPI done for the next 2 quarters and reported in our Quality Assurance Performance Improvement Committee meetings. See attachments labeled K-321	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This REQUIREMENT is not met as evidenced	K 363		9/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING **01** B. WING _____	**09/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE** **EAST HANOVER, NJ 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
K 363	Continued From page 5 by: Based on observation and interview, the facility failed to ensure corridor access doors closed and latched into the frame without impediment and were constructed to resist the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 18.3.6.3. This deficient practice had the potential to affect 44 residents. Findings include: An observation on 09/18/24 at 9:45 AM revealed the door to Soiled Linen room on the Third Floor was taped open, preventing the positive latch from functioning. An observation on 09/18/24 at 10:46 AM revealed the door to Room 2214 failed to latch in the door frame. During an interview at the time of the observations, the U.S. FOIA (b) (6) confirmed the doors failed to latch in the frames. He stated the facility was unaware the doors were not latching. NJAC 8:39-31.2(e)	K 363	What corrective action will be accomplished for those residents affected by the deficient practice? Doors to corridor was checked and latch was replaced, and impeding structure was removed. The Maintenance Director has in-serviced all staff with the correct code to enter the soiled linen rooms, and code is located at nursing station to ensure access is readily available to all staff to prevent recurrence How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Maintenance Director and/or designee will make weekly rounds throughout the facility to ensure all doors are latching properly and nothing is impeding door latch using audit tool A monthly positive latch audit shall be done of all doors in the center and findings will be documented How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING **01** B. WING _____	**09/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE** **EAST HANOVER, NJ 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
K 363	Continued From page 6	K 363	Maintenance Department will monitor for 3 months the results from weekly rounds using the audit tool to report to Quality Assurance Performance Improvement Committee quarterly	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6. 2. This deficient practice had the potential to affect all 71 residents who resided at the facility. Findings include: An observation on 09/18/24 at 10:25 AM of the smoke barrier located in the inside Room 3201, revealed a five-inch by five-inch unsealed overcut	K 372	What corrective action will be accomplished for those residents affected by the deficient practice? The Maintenance Director has used 3/4 thick sheet rock to repair the 5x5 unsealed cutout in the wall of room [NJ Ex Order] then used [NJ Ex] Red Fire Barrier Sealant to close the areas around the wire Maintenance has used the [NJ Ex] Red Barrier sealant to seal around the pipe in the electrical room located on the Second-Floor.	9/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING **01** B. WING _____	**09/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE** **EAST HANOVER, NJ 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
K 372	Continued From page 7 around a conduit penetration above the bed and ceiling. An observation on 09/18/24 at 10:41 AM of the smoke barrier, located inside the Electrical Room on the Second Floor revealed a three-inch unsealed overcut around a pipe penetration. An observation on 09/18/24 at 3:55 PM of the smoke and fire barrier, located on the Ground Floor near the Kitchen revealed gaps and unsealed penetrations in the wall below the ceiling. During an interview at the time of the observations, the U.S. FOIA (b) (6) confirmed the findings and stated the facility was unaware of the unsealed penetrations in the smoke barriers. NJAC 8:39-31.1(c), 31.2(e)	K 372	The gap in the wall near the kitchen was closed with 3/4 thick sheet rock. All gaps and unsealed penetrations in the wall below the ceiling have been resolved. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Maintenance Director and/or designee will make weekly & monthly rounds throughout the facility to ensure there are no penetrations and that recent corrective measures remain in place to prevent smoke transfer and ensure smoke barriers are intact. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Maintenance Department will monitor for 3 months the results from weekly and monthly rounds using the audit tool to report to Quality Assurance Performance Improvement Committee on a quarterly basis See attached pics labeled K-372	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING **01** B. WING _____	**09/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE** **EAST HANOVER, NJ 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
K 920	Continued From page 8	K 920		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to meet the power cords and extension cord requirements of NFPA 70 (2011), Article 400. The deficient practice had the potential to affect staff and residents. Findings include: An observation on 09/18/24 at 11:22 AM of the Maintenance Shop revealed two power strips and an extension cord daisy chained to each other.	K 920	What corrective action will be accomplished for those residents affected by the deficient practice? Power strip and power cord that were daisy chained were removed from Maintenance Shop. The Maintenance staff was in-serviced. How will the facility identify other residents	9/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING **01** B. WING _____	**09/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	**1 SOUTH RIDGEDALE AVENUE** **EAST HANOVER, NJ 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
K 920	Continued From page 9 During an interview conducted at the time of the observation, the U.S. FOIA (b) (6) confirmed the finding and revealed the facility was aware that power strips and extension cords could not be daisy chained together. NJAC 8:39-31.2(e) NFPA 70	K 920	having the potential to be affected by the same deficient practice? All residents and staff have the potential to be affected by the deficient practice What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Maintenance Director and/or designee will make weekly rounds throughout the facility to ensure power strips and power cords are not daisy changed together and are properly mounted. This will be checked and documented monthly by the team. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Maintenance Department will monitor for 3 months the results from weekly and monthly rounds using the audit tool to report to Quality Assurance Performance Improvement Committee quarterly	

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
315529 Y1	A. Building 01 - MAIN BUILDING B. Wing Y2	11/8/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVIA HEALTH AND SENIOR LIVING	1 SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 07936

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	10/03/2024	LSC K0321	09/26/2024	LSC K0363	09/21/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0372	09/26/2024	LSC K0920	09/27/2024	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	
9/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO