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	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Livingston	68 Passaic Avenue Livingston, NJ 07039

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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

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

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	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Livingston	68 Passaic Avenue Livingston, NJ 07039

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint NJ # 2599517 Based on interview and review of medical records, it was determined that the facility failed to ensure there was no delay in implementing a physician recommendation for a burn treatment, and failed to ensure the treatment was ordered for the physician recommended frequency. This deficient practice was identified for 1 of 2 residents reviewed for treatment orders (Resident #1) and was evidenced by the following:On 10/23/2025 at 10:00 AM, the surveyor reviewed the closed Electronic Medical Record (EMR) for Resident #1 which revealed the following: The admission Record (an admission summary) Resident #1 was admitted with diagnoses which included, but were not limited to; alcohol abuse with intoxication, anxiety disorder, bariatric surgery, burns, skin grafts on 79% total body surface area (TBSA) for 2nd and 3rd degree burns. The admission Minimum Data Set, an assessment tool dated 8/14/25, indicated that Resident #1 scored a 15 out of 15 on the Basic Interview for Mental status which indicated that the resident was cognitively intact. On 10/23/25 at 10:30 AM, the surveyor reviewed a physician Consolation Report dated 8/22/25, which revealed under Finding: s/p [status post] 78.5% TBSA 2/3-degree scald burn with extensive Split-Thickness Skin Graft (STSG) to bilateral lower extremities. Please apply Cocoa Butter to all healed areas three times daily. A review of the Physician Order Summary Report dated 8/24/25, revealed the following order: apply Cocoa Butter to bilateral arms every day shift, apply Cocoa Butter to right leg, and apply compression stockings every day shift. (This order was two days after Resident #1 returned from the consultation at the Burn/Wound center and did not match the recommended frequency of three times per day). A review of the Medication Administration Record (MAR), revealed an order to: Apply [NAME] Butter to B/L (bilateral) Arms every day shift -Start Date- 08/25/2025 0700, and an order to apply Cocoa Butter to Right leg and apply compression stockings every day shift. Start Date- 08/25/2025 at 0700 [7:00 AM]. On 10/23/25 at 9:35 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the process when a resident returned with a consultation report. The LPN stated, When a resident returned with recommendations from a consultation visit, the Physician would be contacted to obtain approval for the orders, then the LPN would enter the orders into the EMR. The LPN further stated, if the pharmacy did not have the medication available, the LPN would inform the physician and obtain a hold order until the medication arrived from the pharmacy. The LPN stated the medication should have arrived the same day it was ordered, or the next day. The LPN stated it depended on the time of day that the medication was ordered. The LPN recalled Resident #1's order for Cocoa Butter the LPN then stated she obtained approval for the orders on 8/22/25 (the date of the consultation), and she entered the orders into the EMR. She then stated she was off for a few days and when she returned to work on 8/25/25 the Cocoa Butter was available. She could not recall any further details regarding the order. On 10/23/25 at 12:35 p.m., the surveyor interviewed the Director of Nursing (DON), who stated that she had not been aware that the Cocoa Butter arrived two days after the order was sent to the pharmacy. In addition, the DON stated that she was not aware that the Cocoa Butter was not ordered in the frequency that the Burn/Wound center physician recommended (three times per day), and confirmed it was administered only once per day. The DON acknowledged that the medication should have been available for the resident the day it was ordered, 8/22/25, or the next day depending on the time of day it was ordered. She also acknowledged that the Cocoa Butter should have been ordered three times a day as recommended by the Physician from the Burn/Wound Center. NJAC 8:39 29.2 (d)

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	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Livingston	68 Passaic Avenue Livingston, NJ 07039

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Livingston	68 Passaic Avenue Livingston, NJ 07039

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to ensure a) a resident who was identified as being at Low Risk for developing pressure ulcers did not develop a pressure ulcer, and b) upon the identification of a facility acquired pressure ulcer, a documented wound assessment was completed and new interventions were implemented to prevent further skin breakdown. The deficient practice was identified for 1 of 2 residents reviewed for wounds/skin treatments (Resident #3) and was evidenced by the following:On 10/23/25 at 10:00 AM, the surveyor reviewed the Electronic Medical Record for Resident #3 which revealed the following: A Nursing Progress note dated 7/28/25 at 15:02 (3:02 PM), documented Resident #3 had blanchable thick hard indurated skin on the Left buttock. The skin was not open and no pain was present. The Physician and family were made aware. There was no documented wound assessment completed upon identification of the wound. A Progress Note documented by the Advanced Practice Nurse as a Late Entry and dated 7/30/35 at 14:00 (2:00 PM), failed to address the new wound identified on 7/28/25. A Nursing Monthly Summary, dated 8/1/25 at 11:16 AM, documented There is no skin breakdown or skin condition present. The note failed to address the new wound identified on 7/28/25. A Nursing Progress Note dated 8/7/25 at 21:34 (9:34 PM), documented while on wound rounds the resident was noted to have a partial thickness (extends through the epidermis of the skin) stage 2 sacral Pressure Ulcer, .5-centimeter X .5-centimeter X .2 centimeter (cm) .small amount of serous drainage noted. Placed on a [specialty mattress], provided a [specialty cushion] for the wheelchair, new order provided for every shift zinc oxide . The interventions were added 10 days after the Left buttock wound was identified.The Wound Assessment Report dated 8/7/25, and completed by the wound specialist physician identified the Initial Exam for the above-mentioned Stage 2 Wound. The Initial Exam for the Left buttock identified the Left buttock was identified as an Unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) Pressure Injury Obscured full-thickness skin and tissue loss. The wound measured 10 cm X 7 cm X 0 cm. The Area (square cm based on Length and Width) was 10 square cm and the Volume (cm based on area Depth was 1.A Skin Note, dated 8/10/25, dated 8/10/25, and completed by the Licensed Practical Nurse Unit Manager (LPNUM) revealed: 2.Left buttock is firm to touch,? abscess verse pressure ulcer. (This documentation conflicted with the assessment completed by the wound specialist physician on 8/7/25).A review of the 44-page Care Plan with current and resolved Focus areas revealed a focus area for being at risk for alteration in skin integrity related to decreased physical mobility, history of MASD [Moisture Associated Skin Damage-inflammation and erosion of the skin, resulting from prolonged exposure to moisture such as feces and urine] and incontinence; Date Initiated: 6/18/21. An additional Focus was added by the Director of Nursing (DON) on 7/29/25 which documented on 7/28/25, Blanchable redness to left buttock, area hard to touch. The Goals revealed: Skin will remain free of breakdown within limits of disease process; Date Initiated: 9/14/21; Will decrease/minimize skin breakdown risks, Date Initiated: 6/18/21; Skin will remain intact, free from erythema, breakdown, excoriation or bruising until next review, Date Initiated: 2/9/25. An intervention The Interventions included barrier cream to peri-anal/buttocks as needed and provide preventative skincare routinely and as needed; Date initiated 6/18/21. There were no new interventions added to the Care Plan upon the identification of the wound on 7/28/25. A review of the Physician Orders for July 2025, along with the Medication Administration Record revealed a treatment order dated 8/3/25, to cleanse left buttock with normal saline, cover with dry dressing everyday shift for abscess. The first administration of the order was 8/4/25 (7 days after the wound was initially identified). There were no other treatment orders related to the wound that was identified on 7/28/25 and presented as an unstageable wound on 8/7/25. On 10/23/25 at 12:40 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of another surveyor regarding Resident #3's Left buttock wound identified on 7/28/25. The DON confirmed it was a facility acquired wound. The surveyor asked the DON when the wound was identified, was it assessed or measured? The DON stated, we thought it was an abscess (pocket of pus). The surveyor asked if there was an initial assessment completed when the wound was identified on 7/28/25? The DON stated, I told the nurse to document it because it might open up not something, and the nurse didn't document it. When asked if interventions for wound healing were added when the wound was identified, and the DON stated, barrier cream was already in place. The surveyor asked what should occur when a new wound was identified? The DON stated, there should be a documented assessment. The surveyor inquired if