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	08/21/2025

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the Resident Assessment Instrument (RAI manual), the facility failed to ensure that three residents out of three resident (Resident (R) 28, R50 and R67) out of 22 sampled residents' Minimum Data Set (MDS) assessments were transmitted in a timely manner.Findings include:Review of Center for Medicare and Medicaid Services (CMS) Long-term Care Facility Assessment Instrument 3.0 User's Manual, dated 10/23 revealed, Chapter 2: Assessments for the Resident Assessment Instrument, 2.6: Required OBRA Assessments for the MDS.RAI OBRA-required assessment summary for.discharge return not anticipated assessment.MDS completion date (Z0500B) no later than discharge date + 14 calendar days.Transmission date no later than MDS completion date + 14 calendar days.for annual assessment.MDS completion date no later than Assessment Reference Date (ARD) + 14 calendar days.Transmission date no later than care plan completion date + 14 calendar days.for quarterly assessment.MDS completion date no later than ARD + 14 calendar days.Transmission date no later than MDS completion date + 14 calendar days. 1.Review of R28's admission Record, located under the Profile tab in the Electronic Medical Record (EMR) revealed R28 was re-admitted to the facility on [DATE] with a diagnosis of dementia.Review of discharge return not anticipated MDS assessment with an ARD of 04/29/25 revealed MDS completed on 05/05/25. However, there was no evidence that this assessment was submitted.Review of R28's Assessment History, dated 04/29/25, provided by the facility, revealed Discharge Return Not Anticipated assessment was never added to a batch. 2.Review of R50's admission Record, located under the Profile tab in the EMR revealed R50 was re-admitted to the facility on [DATE] with a diagnosis of dementia.Review of quarterly MDS assessment with an ARD of 07/15/25 revealed MDS completed on 07/29/25. However, there was no evidence that this assessment was submitted.Review of R50's Assessment History, dated 07/15/25, provided by the facility, revealed Quarterly assessment was never added to a batch. 3.Review of R67's admission Record, located under the Profile tab in the EMR revealed R67 was admitted to the facility on [DATE] with a diagnosis of chronic kidney disease.Review of annual MDS assessment with an ARD of 10/10/24, located under the MDS tab in the EMR revealed MDS completed on 10/31/24 and submitted on 11/04/24.Review of Assessment History, dated 10/10/25, provided by the facility, revealed Annual assessment was batched and accepted on 11/04/25.Interview on 08/21/25 at 1:00 PM, the MDS Specialist Registered Nurse (RN) confirmed that the assessments for R28 and R50 were not submitted within the appropriate timeframe. The MDS Specialist Registered Nurse (RN) confirmed that R67's assessment was completed and submitted late and stated that her regional knew. She said that she does not have a check and balance system and was unable to state the last time she checked the missing assessment report. NJAC 8:39-11.2

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	08/21/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure one out of 22 sampled residents (Resident (R)4) was provided with a meaningful, individualized activity program. R4 was not further assessed when the Minimum Data Set (MDS) triggered and indicated she had little interest/pleasure in doing things. The MDS indicated a care plan would be developed to address the care area of activities; however, this was not completed. R4's interests were not fully assessed and she did not have an activity program in place based on her interests and needs. This created the potential for R4 to have a decreased quality of life.Findings include:Review of the facility's Activity Evaluation policy dated February 2023 and provided by the facility revealed, In order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident at least quarterly and with any change of condition that could affect his/her participation in planned activities. An activity evaluation is conducted as part of the comprehensive assessment to help develop an activities plan that reflects the choices and interests of the resident. The activity evaluation is used to develop an individual activities care plan. Each resident's activities care plan relates to his/her comprehensive assessment and reflects his/her individual needs.Review of the admission MDS with an Assessment Reference Date (ARD) of 07/25/25 in the electronic medical record (EMR) under the MDS tab revealed R4 was admitted to the facility on [DATE] with diagnoses including paraplegia (loss of muscle function in the lower half of the body) and stage four pressure ulcer. R4 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating she was intact in cognition. R4 was identified as having little interest or pleasure in doing things half or more of the days in the assessment period. The interview for activity preferences indicated it was very important for R4 to listen to music and be around animals such as pets. It was somewhat important to have books, newspapers, and magazines to read, keep up with the news, go outside to get fresh air, and participate in religious services.Review of the Care Area Assessment (CAA) Summary dated 07/31/25 in the EMR under the MDS tab revealed R4 triggered for further assessment under the care area of Activities and the care area of Activities would be addressed on the Care Plan. Review of the Activity CAA Worksheet dated 07/31/25 revealed R4's activity preference prior to admission was for group activities. No other activity preferences were identified. Health issues resulting in R4's reduced activity participation included depression or anxiety and unstable health problems.The EMR was reviewed and no activity assessment (besides the MDS/CAA), progress notes, or activity care plan were found in R4's record.During an interview on 08/18/25 at 2:46 PM, R4 stated she would like to go to group activities and would love to go outside. R4 stated she had not participated in any group activities since she was admitted and had not gone outside. R4 stated she stayed in bed most of the time and did not know if the facility allowed stretcher bound residents to go to activities. R4 stated her daily activity primarily consisted of participating in therapy, she had a television in her room that she watched occasionally and had some books if she wanted to read.During the survey, R4 was observed to be lying in bed without any activity stimulation in the room on:08/18/25 at 3:05 PM 08/19/25 at 10:38 AM 08/19/25 at 3:13 PM 08/20/25 at 3:49 PM 08/20/25 at 4:45 PM 08/21/25 at 11:37 AM 08/21/25 at 1:42 PM During an interview on 08/20/25 at 3:52 PM Certified Nursing Assistant (CNA)1 stated R4 was alert and oriented and could voice her needs. CNA1 stated R4 stayed in bed and was dependent on staff for most activities of daily living and required a Hoyer lift to get out of bed. CNA1 stated she had not seen R4 attend or participate in any activities; however, stated R4 had a TV and her family visited her in the afternoon/evenings. During an interview on 08/20/25 4:04 PM the Recreation Assistant (RA) stated she made rounds, let residents know what was going on, and took an activity cart to all residents' rooms daily. RA stated R4 had not come out of her room to any activities but on a previous admission, R4 liked to attend trivia. RA stated she did not have planned one-to-one visits based on (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	08/21/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's interests when she went into R4's room. RA stated she offered supplies such as books or puzzles and visited with R4 when she went into her room. During an interview on 08/20/25 at 4:51 PM, the Director of Recreation stated her normal process for newly admitted residents was to meet with them within the first five days of admission and show them where the activity calendar was located. The Director of Recreation stated she completed the Activity Evaluation form to determine what their interests were. The Director of Recreation stated after completing the Activity Evaluation she created an activity care plan and this was done for all residents. The Director of Recreation reviewed R4's EMR and stated there was no Activity Evaluation created for R4, further stating she was not sure what happened. Additionally, the Director of Recreation reviewed the EMR and could not find an activity Care Plan for R4. In regard to R4's interests, the Director of Recreation stated R4 specifically liked dogs, but it was not important for R4 to attend group activities. The Director of Recreation verified R4 had not attended any group activities since admission. The Director of Recreation stated one to one visits were completed daily by the RA and they lasted at least 15 minutes. The Director of Recreation stated the RA brought newspapers, magazines, crosswords, and coloring pages on her cart. The Director of Recreation stated she did not know what items R4 asked for when the RA brought the activity cart to her room.Review of a generic Activity Evaluation form revealed the form was comprehensive in identifying pertinent background information about the resident such as: information about family, voting, education, former occupation, spiritual involvement, language spoken, speech, activity preferences, an extensive list of past and current activity pursuit patterns, preference for activity participation by time of day, preferred activity setting, interest in a job assignment, dietary considerations, communication limitations, behaviors, mode of transportation, etc.Review of the One-to-One Activity Participation Log for R4 revealed visits were conducted daily except for: 07/19/25 - 07/22/25, 07/26/25, 07/27/25, 08/02/25, 08/03/25, 08/08/25 - 08/13/25, 08/16/25, and 08/17/25. They type of visit was noted in each instance as wellness visit.During an interview on 08/21/25 at 11:53 AM, MDS Specialist Registered Nurse (RN) reviewed R4's admission MDS in the EMR and stated R4 triggered in the area of activities due to R4's lack of interest in things. MDS Specialist stated there should have been a Care Plan developed as the MDS Section V indicated activities would be care planned. MDS Specialist RN verified no care plan had been developed until 08/21/25, after the surveyor's inquiries.During a follow up interview on 08/21/25 at 11:42 PM, R4 stated the RA came into her room and talked with her frequently, but they had not done any activities together. R4 stated the RA provided her with an activity calendar and asked if she needed anything in her room. R4 stated she enjoyed pets and today was the first day she had been asked if she was interested in pet visits, stating that she responded that she was interested. R4 stated she had not been provided with pet visits through the activity programming. NJAC 8:39-7.3

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	08/21/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure one out of five residents (Resident (R)70) reviewed for nutrition out of a total of 22 residents was provided with a therapeutic minced and moist diet texture as prescribed by the Physician. R70 was served regular texture food which created the potential for choking or aspiration (accidentally inhaling food or liquid into the airway).Findings include:Review of the facility's Therapeutic Diets policy dated October 2017 and provided by the facility revealed, Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences.Review of the undated admission Record in the electronic medical record (EMR) under the Profile tab revealed R70 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing).Review of the EMR revealed that as of the survey, the Minimum Data Set (MDS) assessment had not been completed for R70.Review of Order Summary Report dated 08/13/25 in the EMR under the Orders tab revealed R70's admission diet order was, Heart healthy diet, minced and moist texture.Review of all the Diet Order & Communication forms (dated 08/14/25, 08/17/25, 08/18/25) between nursing and dietary for R70 revealed she was prescribed a heart healthy diet, minced and moist texture diet during her entire stay through from admission on [DATE] through 08/21/25 (date of survey exit). R70's diet texture had not been changed at any time.Review of a Nursing Progress Note dated 08/15/25 in the EMR under the Progress Notes tab revealed R70 was sent to the hospital on [DATE] at 3:29 AM due to R70 not being herself per her family member who was present and because she was experiencing chest pain.Review of a Nursing Progress Note dated 08/15/25, R70 was readmitted to the facility on [DATE]; she was out of the facility for less than 24 hours.Review of a Nutrition Evaluation dated 08/17/25 in the EMR under the Assessment tab revealed R70 weighed 113.6 pounds and with within the normal weight range with a Body Mass Index (BMI) score of 24. R70 was prescribed a Heart Healthy Minced and Moist diet. R70 was documented with, Functional issues noted affecting the ability to eat. Noted holding food in mouth/cheeks or residual food in mouth after meals. Dining ability: Assistance.Dental/oral issues identified that may impact eating include the following: missing teeth. Identified nutritional problems are as follows: swallowing difficulty; self-feeding difficulty. Nutritional Interventions include the following: Therapeutic diet. Review of the nutrition Care Plan dated 08/17/25 in the EMR under the Care Plan tab revealed a goal of, Will tolerate diet, texture and fluid consistency without signs and symptoms of aspiration. Intervention in pertinent part included, Diet Texture: Minced & Moist.During an interview on 08/18/25 at 3:45 PM, Family Member (F)1 stated R70 was served regular texture foods over the weekend on 08/16/25 and on 08/17/25. F1 stated R70 was served a hot dog on a bun for lunch on Saturday 08/16/25 and for lunch on Sunday she was served a regular piece of chicken. F1 stated there was at least one family member present at all meals to assist R70 with eating and the family had prevented R70 from eating the hot dog and the chicken. F1 stated she reported to the facility nurse manager on the weekend that R70 was not served the correct textured food and she reported her concern to the Speech Therapist on Monday 08/18/25 and the diet order had since been corrected. Review of R70's Tray Card for lunch on 08/17/25 provided by the facility revealed her diet order was Heart Healthy regular texture. The minced and moist texture prescribed by the Physician had been replaced with regular texture. Review of the Daily Spreadsheet dated 08/16/25 for lunch provided by the facility revealed a resident on a regular texture diet would receive a hot dog as the meat entree for lunch. A resident on a minced and moist texture diet would receive a ground hot dog. Review of the Daily Spreadsheet dated 08/17/25 for lunch provided by the facility revealed a resident on a regular texture diet would receive a piece of baked chicken as the meat entree for lunch. A resident on a minced and moist diet would receive ground chicken with gravy or sauce. During an observation on 08/20/25 at 9:26 AM revealed R70's tray card read Heart Healthy Minced and Moist (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	08/21/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	texture diet. She had been served diced scrambled eggs, oatmeal, orange juice and milk and had eaten 50% of her meal. During an interview on 08/20/25 at 11:43 AM the Dining Room Lead and Registered Dietitian (RD) verified that R70 had been served inappropriate food for lunch on 08/17/25. The Dining Room Lead stated she was working in the kitchen and R70's diet slip said regular and not moist and minced. The Dining Room Lead stated the Unit Manager Licensed Practical Nurse (LPN) came to the kitchen on Sunday and informed the dietary staff that the diet texture for R70 was incorrect. The Dining Room Lead stated the dietary staff went by the diet slip provided by nursing which did not include the minced and moist texture. The RD stated R70 went to the hospital on [DATE] and came back late at night and this accounted for the diet texture change. The RD stated it was corrected at lunch on 08/17/25 when R70 had been served regular chicken. The RD stated R70 was on minced and moist texture prior to going to the hospital. During an interview on 08/21/25 at 12:50 PM, Unit Manager (UM) Licensed Practical Nurse (LPN) stated R70 had swallowing problems and her family fed R70 her meals. The UM stated she had been working on 08/17/25 and was called to R70's room by R70's family. The UM stated when she went to the room, she observed that R70 had been served a whole untouched piece of chicken and her tray card indicated regular texture instead of minced and moist. The UM stated she took the tray card to the kitchen and the dietary staff told her that is how the tray card printed out of the tray card system. The UM stated she wrote a new Diet Order & Communication form on 08/17/25 and provided it to dietary staff with minced and moist texture. The UM stated nothing had changed with R70's physician's orders and she did not know how the texture became altered in the tray card system, further stating something in the tray card system had a glitch. The UM stated orders remained in place if the hospitalization was less than 24 hours. The UM stated she notified the RD of the situation. During a follow up interview on RD 08/21/25 at 2:46 PM, the RD stated the UM had sent her an email over the weekend letting her know what happened and asked her to double check it on Monday. The RD stated she did not know how the diet texture got changed in the tray card system as only a few people such as herself and the Dietary Manager (who was on vacation) had access to update the tray cards. The RD stated there was no mechanism to track who or when the change to R70's texture was changed in the tray card system. The RD verified that R70 was not actually admitted to the hospital and her stay was less than 24 hours so there was nothing that would have triggered a new diet slip with a different diet texture. The RD retrieved all the Diet Order & Communication Forms from nursing and verified none specified a regular texture. During an interview on 08/21/25 at 2:09 PM, the Speech Therapist (ST) stated she was working with R70 on eating/swallowing issues and verified R70's diet texture was minced and moist and it had not been changed during her stay. The ST stated she had not been aware that R70 received regular texture foods over the weekend and indicated she was not in the facility on the weekend of 08/16/25 and 08/17/25. The ST stated serving regular texture foods created a potential choking or aspiration risk for R70. The ST stated R70 had a lot of weakness and pocketing on the left side and she only had a couple teeth. The ST stated it was difficult for R70 to tolerate solid foods. The ST stated R70 could somewhat feed herself such as she could lift the cup and spoon but was not able to eat much independently. The ST stated R70's family was with R70 consistently during meals. During an interview on 08/21/25 at 4:15 PM, the Director of Nursing (DON) stated R70 had not been removed from the computer system with a hospitalization of less than 24 hours so there should not have been a different diet order after returning from the hospital on [DATE]. The DON stated the nurses did not have access to the tray card system and could not have changed the diet order. The DON stated she had been made aware of the situation on 08/18/25 and had seen a photograph of the regular diet chicken meal R70 received on 08/17/25 and had also seen a photograph of the tray card that read regular diet instead of minced and moist. The DON stated the situation had been corrected. NJAC 8:39- 17.1

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	08/21/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure one of six residents (Residents (R) 72) reviewed for medication administration out of a sample of 22 residents received medications from the pharmacy as ordered by the physician for administration. This failure had the potential to cause residents to have unmet care needs. Findings include:Review of the facility's policy titled, Medication and Treatment Orders, dated July 2016 revealed, Orders for medications and treatments will be consistent with principles of safe and effective order writing.Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available.Review of R72's Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab revealed the resident was originally admitted to the facility on [DATE] with diagnoses including wedge compression fracture of T11-T12 vertebra, subsequent encounter for fracture with routine healing, chronic myeloid leukemia, protein-calorie malnutrition, and congestive heart failure.Review of R72's EMR under the Physician Orders tab revealed an order, dated 08/07/25, for Cyanocobalamin Oral Tablet 250 MCG (microgram), give one tablet by mouth in the evening for supplement. This order was discontinued on 08/21/25.Review of R72's EMR under the Medication Administration Record (MAR) tab, revealed the medication was not administered on 08/11/25, 08/12/25, 08/14/25, 08/15/25, 08/16/25, and 08/17/25 at 6:00 PM, and was administered for only eight out of fourteen opportunities. The Progress Notes located in the EMR under the Progress Notes tab, revealed that on 08/11/25, 08/12/25, 08/14/25, 08/15/25, 08/16/25, and 08/17/25 the medication was unavailable for administration. Review of R72's Progress Notes located in the EMR under the Progress Notes tab, revealed on 08/21/25, Call placed to (physician) to make him aware.wound that she was admitted with has resolved. Explained to the MD (medical doctor) that currently she has an order for Vitamin B12 250 MCG, which is not available. Made aware that 100 MCG and 500 MCG is available. Per MD since her wound has healed 100 MCG is sufficient. Order placed in chart. Review of R72's EMR under the Physician Orders tab revealed an order, dated 08/21/25, for Cyanocobalamin Oral Tablet 100 MCG (microgram), give one tablet by mouth in the afternoon for supplement. This was the only documented note that the physician was aware that the medication was not consistently available at the previously ordered dosage. During a concurrent interview on 08/21/25 at 9:15 AM, Licensed Practical Nurse/Unit Manager (LPN/UM) stated that she was not aware of why R72 was not consistently getting her Cyanocobalamin Oral Tablet 250 MCG medication, but would find out.During a concurrent interview on 08/21/25 at 10:30 AM, Licensed Practical Nurse/Unit Manager (LPN/UM) and the Director of Nursing stated that they had contacted the physician, and he had changed R72's medication order to one with a dosage that they kept in stock, at 100 MCG instead of 250 MCG, which they did not. The Director of Nursing stated that the EMR had shown that the nurse was calling the pharmacy each day and had contacted the physician. The Director of Nursing and LPN/UM both confirmed that there was no indication documented in the EMR that the physician had wanted to adjust or hold the medication or had been documented as aware that the dosage of the medication was not readily available. They both confirmed that there was no additional documentation in the EMR that any additional steps had been taken to ensure the resident received their ordered supplement. The Director of Nursing said that if a resident had been missing serious medication, she would have expected the nurse to tell her right away so the facility could resolve the problem. The LPN/UM and Director of Nursing stated that they had constantly reminded the nurses to inform them if there was a pharmacy problem. During an interview on 08/21/25 at 12:50 PM, LPN2 said that if a resident's medication was not available for administration, she would contact the pharmacy and then contact the physician. She said if there was going to be a delay in getting the medication, they would ask the (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	08/21/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doctor to change the time of administration to later in the day so the resident would not miss their medication. LPN2 stated that this would be documented in the resident progress note. She said that if it was an over-the-counter drug, they might not have the right dosage because they did not carry every medication dosage. LPN2 said that if the physician ordered a medication for a dosage the facility did not have, she would contact the physician to let them know what dosages they did have in stock. LPN2 confirmed that you had to let the physician know so they could adjust the order.During an interview on 08/21/25 at 1:30 PM, LPN1 said that if she was going to administer a medication that was not available, she would call the pharmacy. She said sometimes the medication would come that day, but sometimes it would not. LPN1 said she would call the physician to let him know, and to see if they would want to hold the medication or give the resident something different. LPN1 stated that sometimes the physician would get back with them, and sometimes they would not, it depended on the physician. LPN1 said this should all be documented in the resident's EMR. During an additional interview on 08/21/25 at 2:25 PM, LPN/UM confirmed that the nurses should have communicated with her and the Director of Nursing if they were having difficulty getting medication in from the pharmacy, but they had not. She stated that the pharmacy did not carry all of the medication doses that they needed, and that it could sometimes be difficult to communicate well with them. She confirmed that there had been some concerns getting the pharmacy to send the medications. LPN/UM said that R72's medication was changed on 08/21/25 to 100 MCG, since they had that more readily available. During an interview on 08/21/25 at 3:55 PM, the Consultant Pharmacist confirmed that the facility had a problem with getting medications from the pharmacy. She stated that the problem came from the medications not being delivered properly. The Consultant Pharmacist said that if a nurse was unable to administer a medication because of some reason, such as the dosage, then they should contact the physician to get the medication order changed, if possible. She again confirmed there had been an ongoing concern with pharmacy delivery. NJAC 8:39-29.2

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	08/21/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure medical records were accurate for two out of two residents (Resident (R)4 and R71) reviewed for activities of daily living (ADLS) out of a total sample of 22 residents. Neither R4 nor R71 had received a tub bath or shower since admission; their medical records indicated they had received tub baths and/or showers. This created the potential for residents not to receive necessary care because their records indicated they had already received the care.Findings include: Review of the facility's Charting and Documentation policy dated July 2017 and provided by the facility revealed, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facility communication between the interdisciplinary team regarding the resident's condition and response to care.1. Review of the admission MDS with an Assessment Reference Date (ARD) of 07/25/25 in the electronic medical record (EMR) under the MDS tab revealed R4 was admitted to the facility on [DATE] with diagnoses including paraplegia (loss of muscle function in the lower half of the body) and stage four pressure ulcer. R4 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating she was intact in cognition. R4 was dependent on staff showers. Review of R4's undated Kardex provided by the facility revealed R4 was to receive showers on Tuesdays and Fridays. Review of the Documentation of Survey Report for 07/18/25 through 08/18/25 and provided by the facility revealed R4 received showers on 08/01/25, 08/05/25, 08/08/25, and 08/12/25. Review of the POC [Point of Care] Response History report from 07/23/25 - 08/20/25 in the EMR under the Tasks tab revealed R4 received tub baths on 07/23/25, 07/24/25, 07/25/25, 07/28/25, 07/29/25, 08/02/25, 08/03/25, 08/04/25, 08/07/25, 08/08/25, 08/12/25, 08/13/25, 08/16/25, 08/17/25, and on 08/18/25. During an interview on 08/18/25 at 2:38 PM, R4 stated she received bed baths daily; however, had not received a shower or tub bath since she was admitted to the facility. R4 verified she was dependent on staff for showers/baths and she rarely got up and out of bed due to significant pressure ulcers/her medical condition. During an interview on 08/21/25 at 12:09 PM, the Unit Manager (UM) Licensed Practical Nurse (LPN) stated R4 had rarely gotten out of bed since she had been admitted to the facility and could only be up for short periods of approximately 30 minutes. The UM stated R4 had not received any showers or tub baths since admission due to her complex medical condition and discomfort being up. The UM stated the facility did not have a tub for tub baths. When informed of documentation of R4 receiving showers and tub baths, the UM stated the documentation was inaccurate. During an interview on 08/21/25 at 4:10 PM, the Director of Nursing (DON) stated R4's bath and shower records were inaccurate. The DON stated R4's Certified Nursing Assistant (CNA) told her she gave thorough bed baths and had therefore coded them as showers. The DON stated a bed bath was not a shower. 2. Review of the undated admission Record in the EMR under the Profile tab revealed R71 was admitted to the facility on [DATE]. Diagnoses included a cerebrovascular accident (stroke) with hemiplegia (paralysis and inability to move one side of the body) and hemiparesis (partial weakness or loss of strength on one side of the body). Review of the admission MDS with an ARD of 08/14/25 in the EMR under the MDS tab revealed R71 was unimpaired in cognition with a BIMS score of 15. R71 required substantial/maximal assistance with showers/bathing self. Review of R71's undated Kardex provided by the facility revealed R71 was to receive showers on Mondays and Thursdays. Review of the Documentation of Survey Report for R71 from 08/07/25 through 08/20/25 provided by the facility revealed she received showers on 08/11/25, 08/14/25, and 08/18/25. Review of the POC [Point of Care] Response History report from 08/07/25 - 08/21/25 in the EMR under the Tasks tab revealed R4 received a shower on 08/12/25. During an interview on 08/19/25 at 11:16 AM, R71 stated that although she had received (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	08/21/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed baths, she had not received a shower or tub bath since she had been admitted to the facility. R71 stated she had a recent stroke and had weakness on one side. R71 stated she would need extensive assistance from staff to get up and take a shower. During an interview on 08/21/25 at 12:20 PM, the UM stated R71 received her first shower today and that she had received only bed baths previously. When informed the record showed she had received four showers prior to today, the UM stated the records were not but should be accurate. During an interview on 08/21/25 at 4:10 PM, the DON stated R71's aide had not coded the shower records accurately and confirmed R71 had not received showers prior to 08/21/25. The DON stated it was her expectation that staff document the provision of care accurately During an observation of the facility's only shower room on 08/21/25 at 4:52 PM, it was determined that there were three shower stalls in the room; however, there were no tubs for taking tub baths. NJAC 8:39-4.1(a)NJAC 8:39-27.1(a)