STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livingston Post Acute Care	348 E Cedar Street Livingston, NJ 07039

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and review of pertinent documentation provided by the facility, it was determined that the facility failed to ensure licensed staff credentials were verified upon hire for 56 of newly hired licensed staff reviewed. The deficient practice was evidenced by the following. 1.On 12/29/25 at 9:49 AM, during entrance conference of Surveyor #1 (S #1) with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Assistant DON (ADON), S #1 asked the LNHA a list of new employees who were hired since the last recertification survey that included their title and date of hire. S #1 also notified the LNHA that all new hired employee files and medical records must be provided to the survey team as soon as possible. On 1/2/26 at 10:02 AM, S #1 met with the LNHA and asked about the loose files that she mentioned to the surveyors that she found with regard to new employees files. The LNHA stated that the Human Resource Manager (HRM) was on a leave, and the employee files were very disorganized and that was the reason why there were loose files and not in the new employee files. The LNHA confirmed that there were other documents that they were unable to account for. The total new employee hired since last recertification was 228 per paper provided by the LNHA. On 1/2/26, Surveyor #2 (S #2) reviewed the employee files that were provided to the survey team and revealed that Staff #43, 44, 45, 48, 50, 51, 53, 54, 55, 56, 58, 59, 60, 121, 122, and 124 did not have documented evidence that the previous employment reference checks were performed prior to the date of hire (doh). 2. On 1/2/26 at 1:00 PM, Surveyor #3 (S #3) reviewed the facility's provided new employee files. A review of the new employee files revealed there were no reference checks upon hire for Staff # 62, 64, 65, 66, 67, 68, 69, 70, 71,72, 73, 74, 75, 78, 79, and 80. 3. On 1/2/26 at 8:52 AM, Surveyor #4 (S #4) reviewed the facility's provided new employee files. Further review of the new employee files revealed there were no reference checks upon hire for Staff #83, 88, 89, 90, 92, 95, 96, 98, 99, 102, 103, 104, 105, 106, 107, 108, 109, 110, 115, 116, 117, 118, 119, and 120. On 1/5/26 at 12:10 PM, Surveyor #5 (S #5) asked the LNHA about the missing reference checks for new employees, and the LNHA stated, When I do the reference check, I complete the form or note on the form that the reference was called. She continued, If the form is not filled out, I did not complete the reference check, and I do not know what happened. On 1/5/26 at 1:21 PM, the LNHA did not provide additional information to S #5 about the reference checks that were missing. (continued on next page)

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
	315526	A. Building B. Wing	01/05/2026

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/5/26 at 1:00 PM, Surveyor #6 (S #6) notified the LNHA of the above concern of missing reference checks. On 1/5/26 at 1:35 PM, the LNHA did not provide additional information regarding the above concerns. NJAC 8:39-43.15

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	315526	A. Building B. Wing	01/05/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, it was determined that the facility failed to evaluate the need for the continued use of an indwelling catheter for a resident who were admitted to the facility with an indwelling catheter, failed to include catheter care in the comprehensive care plan and provide appropriate and sufficient care specifically by having the catheter tubing in contact with the floor. This deficient practice was identified for 2 of 2 residents (Resident #8, Resident #171), reviewed for indwelling catheter use and was evidenced by the following:1.On 12/29/25 at 10:56 AM, Surveyor #1 (S #1) observed Resident #8 lying in bed asleep, and an indwelling catheter (Foley) bag hung from the left side of the bed with a privacy bag. On 12/30/25 at 12:19 PM, S #1 reviewed the medical records of Resident #8 and revealed: A review of the admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with medical diagnoses that included but was not limited to; metabolic encephalopathy due to urinary tract infection (UTI), dementia moderate without behavioral disturbance, psychotic, mood, and anxiety disturbances. A review of the comprehensive Minimum Data Set (MDS), an assessment tool to facilitate the plan of care, with an assessment reference date (ARD) of 11/27/25, reflected a Brief Interview of Mental Status (BIMS) score of 3 out of 15 indicating severe impaired cognition. The MDS also indicated that the resident had a Foley catheter with no corresponding diagnosis. A review of the Order Summary Report (OSR) for November 2025, which did not reflect a physician's order (PO) for the Foley catheter until 12/29/25. There was no evidence that the facility staff obtained a PO for the Foley catheter use and care for 39 days from the time the resident was admitted to the facility. The OSR reviewed were as follows: -Ordered 12/29/25, measure and record urine output end of shift; If total output for shift is less than or equal to 200 ml (milliliters), notify MD (medical doctor) every shift. -Ordered 12/29/25, may apply leg bag when out of bed only and replace with large drainage bag when in bed every shift. -Ordered 12/29/25, Foley catheter present every shift. -Ordered 12/29/25, catheter care every shift every shift. -Ordered 12/29/25, change foley catheter PRN (as needed) with indication of infection, obstruction or leakage. Document reason for change in progress notes (PN). -Ordered 12/29/25, change foley bag weekly every night shift every Wednesday. A review of the Care Plans (CP) revealed below: Resident had impaired cognitive function/dementia or impaired thought processes, date initiated 11/21/25. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident required Enhanced Barrier Precautions (EBP). Noted interventions that included indwelling device, date initiated: 11/21/2025. A review of the Admission/readmission Evaluation-nursing note dated 11/20/25 at 9:57 PM, revealed under Section J. Bladder/Bowel Catheter Present-Yes. A review of a Professional Services Physician PN dated 11//21/25 at 3:21 PM, did not indicate the diagnosis for the use of the Foley catheter, and documented that the UTI (urinary tract infection) was resolved. On 12/31/25 at 11:36 AM, S #1 interviewed the second floor Charge Nurse and the MDS Coordinator #1 (MDSC #1), regarding the diagnosis and the reason for the resident admitted with a Foley. The Charge Nurse reviewed all the physician notes and stated that she did not see anything about foley, nor documented about diagnosis or notes documented by the physician for the use of foley. The Charge Nurse further stated that the resident was admitted with the catheter and a UTI. S #1 asked the Charge Nurse and MDSC #1, if a resident was admitted with a Foley, should there be an evaluation for the medical justification for catheter use, diagnoses for the catheter and assessed for a trial removal of the catheter. There was no response from the Charge Nurse and MDSC #1. Later on, MDSC #1 stated that it was the MDS Coordinator #2 (MDSC #2) who reviewed the resident's MDS. On 12/31/25 at 12:33 PM, S #1 interviewed MDSC #2, who completed the 11/27/25 MDS. S #1 reviewed the MDS with the MDSC #2 and asked why a diagnosis was not coded for the Foley. MDSC #2 stated she would get back to S #1 with the answer. S #1 asked the MDSC #2 if the physician should have been queried regarding the use of the catheter and its diagnoses and no response. On 1/5/26 at 11:27 AM, S #1 met with the License Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant DON (ADON), and the Nurse Consultant (NC) regarding the above concerns with the indwelling catheter not being assessed on admission for valid medical justification for catheterization. A review of the facility's Management of the Patient with an Indwelling Catheter Policy revealed under Purpose, to prevent complications associated with indwelling catheterization. Under Procedure #2. When the patient is admitted with a urinary catheter, the catheter is to be removed within 24 hours per PO unless the PO differently . 2. On 12/29/25 at 11:34 AM, during the initial tour of the facility, Surveyor #2 (S #2) observed Resident #171 in their room sleeping in a low bed with the door to the room closed. S #2 observed the catheter tubing hung low to the floor and the catheter bag, enclosed in a privacy bag, also hung and touching the floor. S #2 reviewed the electronic medical record (eMR) of Resident #171, which revealed the following: A review of the AR that reflected that the resident had diagnoses of but not limited to; cerebral infarction, essential hypertension (high blood pressure), and generalized muscle weakness. A review of Resident #171's BIMS Evaluation, dated 10/29/25, reflected that the resident could not be assessed due to memory problems and was severely cognitively impaired. A review of Resident #171's comprehensive MDS), with an ARD of 11/4/25, Section H, revealed that (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident was assessed to have an indwelling urinary catheter. A review of the CP, dated 10/28/25, did not reveal any focus, goal or interventions that the resident has an indwelling urinary catheter, (a device inserted into the bladder to facilitate urine flow through a tube which is collected in an external bag). The CP did reflect that the resident did have an IV (intravenous) catheter (a device usually inserted into a vein to facilitate administration of medications). A review of the resident's OSR revealed that the resident had the following PO: -Catheter care every shift every shift. Dated 10/29/25. -Change foley bag weekly every night shift every Wednesday. Dated 10/29/25 -Change foley catheter PRN with indication of infection, obstruction or leakage. Document reason for change in PN PRN. Dated 10/29/25. On 12/31/25 at 11:24 AM, S #2 interviewed the Assistant Director of Nursing (ADON). S #2 asked what the procedure was for a CP. The ADON stated that the care team meets, goes through the medical record and discussed the resident's general condition for care areas to add or revise as required. S #2 asked if a urinary catheter should be part of the CP, and the ADON stated yes, if the resident was admitted with one it would be in the initial CP or it would be a revision if it was newly added. On 12/31/25 at 12:00 PM, S #2 interviewed the DON and the LNHA. S #2 asked if urinary catheter tubing and bags should be kept off the floor, and the DON stated yes, they should be off the floor but below the level of the bladder for proper draining. S #2 notified the LNHA and DON of the urinary catheter concerns. On 1/5/26 at 10:55 AM, S #2 met with the LNHA, DON, ADON, and NC, and the DON stated that catheter bags and tubing should not be on the floor and should be checked regularly, and an in-service education was done for including it in the CP. The LNHA did not provide any further pertinent information. A review of the facility's Management of the Patient with an Indwelling Catheter Policy, dated updated 4/2025, the policy reflected under 7.d. Never allow drainage bag or tubing to touch floor . A review of the facility's Care Plans, Comprehensive Person Centered Policy, dated 5/2025, reflected under 6.b.services that are to be furnished to attain or maintain the resident's highest practicable physical.well-being. e. reflects currently recognized standards of practice for problem areas and conditions .10. The interdisciplinary team reviews and updates the CP. NJAC 8:39-27.1(a); 27.2(n)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, record review, and review of other facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure; a.) disposition of a narcotic medications for 2 Unsampled Residents (Unsampled Residents #1 and 2), b.) the backup controlled medications cycle count was routinely done, and c.) backup controlled medications discrepancies were resolved in a timely manner, for 3 Unsampled Residents (Unsampled Residents #3, 4, and 5), in accordance with the regulation for accurate reconciliation and accountability. The deficient practices were identified on 2 of the 4 medication carts inspected in 2 of 2 nursing units, and 1 of 1 backup up machine observed, and was evidenced by the following:Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1.On 12/29/25 at 11:07 AM, the surveyor in the presence of Licensed Practical Nurse #1 (LPN #1) inspected the medication cart #1 (medcart #1) for controlled medications (meds), OTC (over the counter) meds, and residents' meds. The surveyor asked LPN #1 to do random controlled meds count in the presence of the surveyor. The surveyor observed Unsampled Resident #1's (UR #1's) Pregabalin (Lyrica) 50 mg (milligrams) capsule (cap) bingo card (a bingo card for meds is typically referred to by the following medical and pharmaceutical terms for blister pack, and this type of packaging is a card, often with 30 compartments, designed to hold a resident's monthly supply of med in an organized way) with remaining one cap while the Individual Patient Controlled Substance Administration Record-30 dose (also known as the declining sheet) reflected that there should be two more capsules (caps) of the med Lyrica. On that same date and time, LPN #1 informed the surveyor that she forgot to sign when she administered the Lyrica today to UR #1. LPN #1 also stated that I was in a hurry that was why she forgot to sign. She further stated that definitely she should have signed once she took the medication (med). 2. On 12/29/25 at 11:17 AM, the surveyor asked the Licensed Practical Nurse/Unit Manager (LPN/UM) where the backup for controlled meds and what was the facility's process with regard to cycle count (for controlled meds is the frequent, scheduled physical counting of a small portion of high-risk drugs (like opioids, stimulants) to ensure physical stock matches electronic records, catching diversion, errors, and discrepancies quickly, rather than waiting for annual audits). The surveyor also asked for the cycle count. The LPN/UM stated that the cycle count as facility's practice, was to do it once a day by two nurses. She also stated that there was a logbook where the nurses signed a paper to confirm the cycle count was done. The LPN/UM also added that if there were discrepancies, it would be resolved asap (as soon as possible) within the day. On that same date and time, the LPN/UM provided the binder with paper: [name of backup machine] Narcotic Count, Month/Year: Nov (November)/2025 and there were no other paper for cycle count. The surveyor asked the LPN/UM as to why there was no December 2025 cycle count log, and she responded that she unintentionally wrote November for December 2025. At that same time, the LPN/UM asked Licensed Practical Nurse #2 (LPN #2) to witness the cycle count in the presence of the surveyor. After the cycle count of controlled meds, the (continued on next page)

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	315526	A. Building B. Wing	01/05/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surveyor asked the LPN/UM to provide a copy of the printed cycle count. The surveyor also observed a red flagged discrepancy in the backup machine and revealed discrepancies for the following dates and controlled meds:-Unsampled Resident #3 (UR #3), date of discrepancy (DOD) 12/22/25, Lorazepam (also known as Ativan, an anti-anxiety med) 1 mg, qty (quantity) expected was 47, qty found was 46, adj (adjusted) down 1 qty remaining 46.-Ativan 1 mg tablet (tab), DOD 12/23/25, qty expected 45, qty found 46, adj up 1 remaining 46.-Clonazepam (also known as Klonopin, an anti-anxiety med) 0.5 mg tab, DOD 12/26/25, qty expected 22, qty found 21, adj down 1 qty remaining 21.-Unsampled Resident #4 (UR #4), Oxycodone IR (immediate release) 10 mg tab, DOD 12/27/25, qty expected 32, qty found 31, adj down 1 qty remaining 31.-Unsampled Resident #5 (UR #5), Lyrica 50 mg cap, DOD 12/28/25, qty expected 27, qty found 26, adj down 1 qty remaining 26.-UR #5, Xanax 0.25 mg, DOD 12/28/25, qty expected 38, qty found 37, adj down 1 qty remaining 37.-UR #5, Xanax 0.25 mg, DOD 12/29/25, qty expected 36, qty found 37, adj up 1 qty remaining 37.-UR #5, Lyrica 50 mg cap, DOD 12/29/25, qty expected 25, qty found 26, adj up 1 qty remaining 26. At that time, the LPN/UM stated that because of the holiday, the discrepancies were not resolved and addressed timely. She further stated that it would be resolved today. She confirmed that the discrepancies should be resolved within the day. The surveyor asked the LPN/UM what the facility's practice and policy with regard to discrepancy was. The LPN/UM responded that there were no reports to generate, no investigation needed, and none to report to with regard to discrepancies with controlled meds. She also stated that the discrepancies would be resolved in the unit. The surveyor asked for printed copies of cycle counts for December 2025 and the discrepancies observed today from 12/22/25 to 12/29/25, and she stated that she would get back to the surveyor. On 12/29/25 at 11:47 AM, the surveyor immediately met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Nurse Consultant (NC), and Assistant Director of Nursing (ADON). The surveyor asked what the facility's process and policy with regard was to cycle count and discrepancy for controlled meds, how often cycle count should be done, and who was responsible for it. The DON stated that cycle count should be done every shift, and she was unsure if there was a log in the backup machine system itself. The NC (also known as the Regional Nurse) stated that the cycle count should be done at least once a day per policy and process, and nursing was responsible. The DON also stated that when discrepancy happened during cycle count, the nurse should notify the DON and incident report should be initiated. The surveyor notified the LNHA, DON, ADON, and NC of the above concerns with regard to backup controlled meds log and discrepancies. On that same date and time, the NC stated that if the discrepancy was just miscounted it can be resolved in the unit and no need to do incident report. The surveyor then asked how do you determine a miscounted meds, and the facility management did not respond. The surveyor asked for policy with regard to cycle count, copy of December 2025 cycle count reports, and discrepancy reports. On 12/30/25 at 9:32 AM, the surveyor interviewed and asked the LNHA and ADON (also the assigned Infection Preventionist) regarding the above concerns. The surveyor notified the LNHA and ADON that the documents that were provided today at 8:15 AM were the undated Policy and Procedure for Back-Up meds via [backup machine name] and the [backup machine name]Transactions by Item/Procedure for cycle count for date range of 12/1/25 to 12/31/25, with a total of 8 out of 29 days in December 2025 (12/8/25, 12/9, 12/19, 12/23, 12/24, 12/26, and 12/29/25) that the facility did the cycle count, and on 12/22/25, 12/27/25, and 12/28/25 discrepancies there were no cycle count that were done. At that time, the LNHA stated that they did not need to do an incident report because there was no loss or missing meds, it wasjust mis-counted meds. On 12/30/25 at 10:30 AM, the LNHA was unable to determine how many nurses should be doing the cycle count. The LNHA also stated that if there was a discrepancy, it should had been investigated at that same time by the Supervisor/DON/ADON, report should be documented if there was a discrepancy either with missing meds, or not an error in counting only. The LNHA further stated, I don't know if there should be a report if there were no actual missing meds. At that same time, the surveyor asked the LNHA if she was aware of the above concern with (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cycle count and discrepancies from 12/22/25 to 12/29/25, and the LNHA responded that I was not aware of the concern before, and not until surveyor's inquiry. The LNHA stated, We did education that they should be aware of what they (nurses) were doing. The LNHA stated that according to the DON after investigation, there were no missing meds, and it was only miscounted and we are still gathering the documentation that we needed. On 12/30/25 at 11:50 AM, the surveyor notified the LNHA and the ADON of the concern that the provided printed report by the ADON had a 72 hour information that included for dates 12/27/25, 12/28/25, and 12/29/25, and there were no resolved printed information for 12/22/25, 12/23/25, and 12/26/25 as indicated in the concern of the surveyor. The ADON checked the provided printed reports for discrepancies and confirmed the missing dates. On 12/30/25 at 12:04 PM, the surveyor interviewed Licensed Practical #3 (LPN #3), who informed the surveyor that he was unaware of controlled meds discrepancies from the backup machine and was not spoken with by either LNHA or DON about the above matter. He confirmed that he worked on 12/27/25 at around 8:00 PM and took Oxycodone IR in the presence of the Nursing Supervisor (NS). He further stated that he did not notice an error or discrepancy at that time. At that same time, LPN #3 stated that he did not receive prior education about the backup machine and not even yesterday. He also stated that if there will be a discrepancy, he knew he need to call the supervisor to notify, and the supervisor will do the rest. On 12/30/25 at 12:14 PM, the surveyor interviewed Licensed Practical #4 (LPN #4), who informed the surveyor that he was not aware of the above concern with miscounted discrepancy with backup machine. He confirmed that he received education about the backup machine but unable to remember the date. LPN #4 further stated that he worked on 12/22/25 and 12/23/25, unable to remember if he took controlled meds for Unsampled Resident #3 (UR #3), but he remembered probably witnessed for another nurse. He added that he did not remember that he had discrepancy observed in the backup machine. At that same time, LPN #4 stated that when there was a discrepancy in the backup machine for controlled meds, he would call the NS, and after that he did not know what else had to be done. On 1/2/26 at 10:18 AM, the surveyor met with the LNHA, ADON, and the DON informed the surveyor that after investigation, there were no missing controlled meds in the backup machine, and everything were reconciled after surveyor's inquiry. He also confirmed that the Quality Assurance Performance Improvement (QAPI) was initiated for the above concern after surveyor's inquiry. The DON also stated that there were discrepancy with LPN #4's provided written statement to the surveyor with regard as to when the discrepancy was found, it should have been after surveyor's inquiry. At that same time, the ADON confirmed that the nurses not aware on how to resolve the discrepancy in the backup machine and may not had an access to resolve it. The ADON stated that it would be the ADON and DON only had access to resolve discrepancies. The DON stated that the nurses did not know that the actual found should be how many meds they saw in the backup machine, and not minus what they were taking out, that was why there were discrepancies. A review of the undated facility's Policy and Procedure for Backup Medications via [name of backup machine] that was provided by the LNHA, revealed, under Discrepancy Reporting and documentation: 1. Whenever a drawer open, the [backup machine name] Station will ask the user to verify the inventory count. If the [backup machine name] Station count is found to be different from the users count, then the user must correct the inventory count before the med is removed, refilled etc. Anytime that a count is corrected, a discrepancy is flagged. After being asked to verify the count 2 times, a red flag will appear on the [backup machine name] screen, indicating a discrepancy has been created. ANY discrepancies created should be reported to the Charge Nurse or Supervisor at the time the discrepancy is created. 2. The Charge Nurse/Supervisor is responsible for generating a discrepancy report before the end of the shift to identify open, unresolved discrepancies. He/She is responsible for investigating nursing activity and getting the discrepancy resolved (this may include reviewing previous withdrawals, validating administration, calling Pharmacy for previous drug withdrawal history, etc.). 4. Resolution of any controlled med discrepancy should occur immediately upon discovery. The nurse with prior access to the med in question should be contacted immediately. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy states that the nurse with prior access may be phoned if necessary. 5. Any unresolved med discrepancy will be documented in the [backup machine name] station as Discrepancies-Unresolved. The Pharmacy Technician or Manager will review all open discrepancies and notify the respective Nurse Manager/DON via email/phone of the unresolved discrepancy(ies) . 3. On 1/2/26 at 11:00 AM, the surveyor inspected 2nd floor medcart #4, in the presence of the Registered Nurse (RN), and both observed discrepancy with Unsampled Resident #2's (UR #2's) Clonazepam (also known as Klonopin, an anti-anxiety med) 0.5 mg tab. UR #2' declining sheet for Klonopin reflected 36 tablets (tabs) while the bingo card had total of 35 tabs remaining, had 1 discrepancy. The RN stated that she administered at 9:00 AM the med and forgot to sign because she was responding to a resident's call. The RN confirmed that she should have signed after removing the med from the bingo card. On 1/2/26 at 12:53 PM, the surveyor interviewed the DON with regard to controlled meds in medcarts. The DON stated, when nurse popped the controlled med bingo card they should sign it immediately, unless they were prevented to signing immediately because they had to address the resident's needs. The DON stated that you take it you sign it. On that same date and time, the surveyor notified the DON of the concern with UR #1's Lyrica, and UR #2's Klonopin declining sheets and the bingo cards did not match when the surveyor did the medcarts inspection on 12/29/25 and 1/2/26. On 1/5/26 at 11:11 AM, the survey team met with the LNHA, DON, NC, and ADON. The LNHA confirmed that the best practice was to sign immediately once controlled med was removed from the bingo card. On that same date at 11:25 AM, the NC stated that nurse could sign the declining sheet before the end of shift. On 1/5/26 at 1:19 PM, the LNHA informed the survey team that there were no further information to provide, and the survey team could proceed with decision making. NJAC 27.1(a), 29.4(k), 29.7(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livingston Post Acute Care	348 E Cedar Street Livingston, NJ 07039

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, it was determined that the facility failed to inform the resident's representative in advance of treatment risks and benefits, options, and alternatives to a resident receiving psychoactive medications. This deficient practice was identified for 1 of 5 residents (Resident #8), reviewed for unnecessary meds.This deficient practice was evidenced by the following:On 12/29/25 at 10:56 AM, the surveyor observed Resident #8 lying in bed asleep. On 12/30/25 at 12:19 PM, the surveyor reviewed the medical records Resident #8, and revealed:A review of Resident's #8 admission Record (an admission summary) reflected diagnoses which included but not limited to; metabolic encephalopathy (brain dysfunction caused by a chemical imbalance or systemic illness) due to urinary tract infection (UTI), dementia (loss of intellectual functioning) moderate without behavioral disturbance, psychotic, mood, and anxiety disturbances, and psychosis (a severe mental condition in which thought and emotions are so affected that reality is lost). A review of the comprehensive Minimum Data Set (MDS), an assessment tool which facilitates the plan of care, with an assessment reference date (ARD) of 11/27/25, reflected a Brief Interview Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. The MDS included that the resident had no behaviors exhibited and was on an antipsychotic medication (med). A review of the Order Summary Report (OSR) and the electronic Medication Administration (eMAR) for November 2025, revealed Resident #8 had an order on 11/20/25 for Quetiapine Fumarate Tablet (Seroquel) 25 mg (milligram), give 0.5 tablet (tab) by mouth at bedtime for psychosis for 5 Days, 0.5 tab=12.5 mg. The Seroquel was administered on 11/20/25 to 11/24/25 for a total of five days. A review of the resident's care plan revealed a focus about impaired cognitive function/dementia or impaired thought processes, date initiated on 11/21/25; uses antipsychotic med (quetiapine). A review of the physician progress note (PN) text dated 11/28/25 at 4:22 PM, revealed . admitted following hospitalization for encephalopathy due to UTI (urinary tract infection), remains confused and bedbound.On 12/31/25 at 11:48 AM, the surveyor reviewed the antipsychotic med Seroquel with the Licensed Practical Nurse/Charge Nurse (LPN/CN) from the second floor, and MDS Coordinator #1 (MDSC #1) in the nursing unit. The surveyor asked if the Resident Representative (RR) was given advanced notice before administration of the Seroquel and what the process for antipsychotics med was. The LPN/CN stated the process was that the resident must be seen by inhouse psychiatrist if on antipsychotic med. The surveyor asked if they were aware of the regulation for antipsychotic medications (meds). The surveyor also asked the LPN/CN to provide documentation that resident was seen by psychiatrist and that RR was informed in advance. The LPN/CN stated, I am not aware of the regulation for antipsychotics. At that same time, MDSC #1 stated that she was familiar with the regulation and since she was a readmission and had been on that med for a long time, there was no need to get consent again. The LPN/CN also stated that the IDT (interdisciplinary team) met on admission and reviewed meds with RR and residents. The surveyor requested to provide documentation that RR was informed of antipsychotic order before administration. On 12/31/25 at 1:00 PM, the License Nursing Home Administration (LNHA) provided an IDT PN by the Social Service dated 8/20/24, and revealed that the IDT reviewed meds with the RR. There was no documentation provided for informing the RR of antipsychotic use for the November 2025. On 1/5/26 at 9:26AM, the surveyor notified the LNHA that the IDT PN that was given to the surveyor was from 2024. The surveyor requested for any additional documentation regarding RR with regard to above concern with an antipsychotic use for the resident including Psychiatry notes or Physician notes for November 2025. On 1/5/26 at 10:00AM, the LNHA informed surveyor that there were no notes stating that the RR was informed of antipsychotic use, and that the Psychiatry consult was done from the previous admission but not the November 2025 admission. On 1/5/26 at 11:03 AM, the surveyor reviewed the physician hospital records, dated 11/20/25, there were no documented evidence that the RR was informed of Seroquel med use. On 1/5/26 at 11:27 AM, the survey team met with the LNHA, Director (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. Building B. Wing	01/05/2026

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Nursing (DON), Assistant DON (ADON), and the Nurse Consultant, and the surveyor notified them of the above findings and concerns with regard to use of antipsychotic med. On 1/5/26 at 1:19 PM, the LNHA confirmed that the RR was not informed and Psychiatry did not see the resident. The LNHA did not provide additional information. A review of the facility's Antipsychotic Medication Use Policy dated July 2022, revealed under Policy Interpretation and Implementation #13. Residents (and/or RR) will be informed of the recommendation, risks, benefits, purpose, and potential adverse consequences of antipsychotic med use . NJAC 8:39-4.1(a)2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. Building B. Wing	01/05/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure 3 of 26 residents (Residents #2, #15, and #171) call bells were within reach and able to use to accommodate residents' needs. This deficient practice was evidenced by the following: 1.On 12/29/25 10:34 AM, during the initial tour of the facility, Surveyor #1 (S #1) observed Resident #2, sleeping in bed, with the call bell hung off side of the bed with the cord wrapped around the side rail. S #1 observed that the call bell was not within reach of the resident. S #1 reviewed the electronic medical record (eMR) of Resident #2, which revealed the following: A review of the admission Record (AR; an admission summary) that reflected that the resident had diagnoses of but not limited to; generalized muscle weakness, cerebral infarction (commonly known as a stroke), and aphasia (difficulty in communicating). A review of Resident #2's comprehensive minimum data set (cMDS), an assessment tool, with an assessment reference date (ARD) of 12/13/25, reflected that the resident had a brief interview for mental status (BIMS) score of 3 out of 15, which indicated the resident had severe cognitive impairment. Further review of the cMDS revealed under section GG (Functional Abilities and Goals) that Resident #2 required substantial or maximal assistance to roll side to side. A review of the Comprehensive Care Plan (CCP) dated 10/8/25, revealed a focus that the resident had limited physical mobility and an intervention that the resident had bed mobility assist of one person. 2. On 12/29/25 at 11:33 AM, S #1 observed Resident #171 in their room sleeping in a low bed. S #1 observed the call bell hung off side of bed with the cord wrapped around the side rail. S #1 observed that the call bell was not within reach of the resident. S #1 reviewed the eMR of Resident #171, which revealed the following: A review of the AR that reflected that the resident had diagnoses of but not limited to; cerebral infarction, essential hypertension (high blood pressure), and generalized muscle weakness. A review of Resident #171's BIMS Evaluation, dated 10/29/25, reflected that the resident could not be assessed due to memory problems and was severely cognitively impaired. A review of Resident #171's Skilled Nursing Evaluation, (a comprehensive assessment that evaluates physical and mental condition, cognitive patterns, functional capacity, nutrition, medications, and social well-being), dated 12/3/25, reflected under Section K, part h, that the resident required partial/moderate assistance to roll left and right. A review of the CCP dated 10/28/25, revealed a focus that the resident had limited physical mobility and an intervention that the resident had bed mobility assist of two. The CCP also reflected a focus that the resident was at risk for falls and had an intervention of be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. Building B. Wing	01/05/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/31/25 at 12:00 PM, S #1 interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). S #1 asked if call bell devices should always be within reach of the resident, and the LNHA stated yes, they should be within reach. S #1 notified the LNHA and DON of the call bell concerns and showed the LNHA and DON the pictures of the call bells in question. The LNHA acknowledged that the call bells were not within reach. On 1/5/26 at 10:55 AM, S #1 met with the LNHA, DON, Assistant Director of Nursing (ADON), and Nurse Consultant (NC), and the LNHA stated that call bell audits and placement checks were done regularly, and the call bell can fall off the bed at any time due to movement or other reason. 3. On 12/29/25 at 10:25 AM, Surveyor #2 (S #2) observed Resident #15 lying in bed with the call bell dangling from the bedside rail behind the resident, not within reach. S #2 asked the resident if they could locate the call bell, and the resident was unable to do so. At that time, S #2 asked the Certified Nursing Aide's (CNA's) assistance with regard to above concern. The surveyor observed the CNA repositioned the call bell and placed it within the resident's reach. On 12/31/25 at 9:45 AM, S #2 conducted a second observation of Resident #15, and S #2 observed the resident was seated in their wheelchair with a bedside tray table positioned in front of them. The call bell was observed lying on the floor next to the bed, out of the resident's reach. S #2 asked the resident if they could locate the call bell, and the resident was unable to do so. At that time, the surveyor notified the Licensed Practical Nurse (LPN) of the above concern and both went back to Resident #15. Upon entering the room, both S #2 and the LPN observed a CNA making the bed, and the call bell had been placed on the reclining chair, still out of reach. The LPN immediately corrected the CNA and instructed her to ensure the call bell was always placed within reach. S #2 reviewed the eMR of Resident #15, which revealed the following: A review of the AR revealed that the resident was admitted to the facility with the following diagnosis but were not limited to; senile degeneration of the brain, dementia with psychotic disturbance, schizoaffective disorder, rheumatoid arthritis, spinal stenosis, essential hypertension, macular degeneration, and multiple chronic conditions. A review of the quarterly MDS, with an ARD of 11/7/25, reflected a BIMS score of 11 out of 15, indicating moderate cognitive impairment. A review of the CCP, dated 11/2025, reflected a focus that the resident was at risk for falls and interventions included ensuring the call bell was within reach and encouraging the resident to use it for assistance as needed. On 12/31/25 at 12:00 PM, S #2 notified the LNHA and DON of the above findings and concerns. S #2 asked the LNHA and DON whether call bells should always be positioned within a resident's reach, the LNHA confirmed that they should. The LNHA acknowledged the concern and explained that call bells can occasionally fall off the bed due to resident movement but emphasized that staff were responsible for ensuring they remain accessible. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. Building B. Wing	01/05/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Call System, Resident, Policy dated updated 4/2025, the policy reflected under 1. Each resident is provided with a means to call staff directly for assistance from his/her bed or other sleeping accommodations . The LNHA did not provide any further pertinent information. NJAC 8:39-27.1(a); 29.2(d); 31.8(c)(9)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to adequately monitor target behavior for the use of a psychotropic medication specifically an antipsychotic medication for 2 of 5 residents (Resident #4 and #9), reviewed for unnecessary medications. This deficient practice was evidenced by the following:1. On 12/29/25 at 10:35 AM, the surveyor observed Resident #4 seated on a couch in their room. A review of Resident #4's admission Record (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses which included, but not limited to; fracture of neck of right femur (a type of hip fracture, broken bone), unspecified dementia with other behavioral disturbance (a form of dementia where the underlying cause is unknown, and the individual experiences a range of behavioral and psychological changes beyond the typical memory and cognitive decline associated with dementia) and anemia (problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). A review of Resident #4's most recent significant change in status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 08 out of 15, which indicated that Resident #4's cognition was moderately impaired. Further review indicated that the resident was taking or had taken in the last seven days or since admission/entry or readmission an antipsychotic medication (prescribed to manage psychosis, primarily in individuals with schizophrenia but also can reduce or relieve symptoms of psychosis, such as delusions (false beliefs) and hallucinations (seeing or hearing something that is not there) and that it was received on a routine basis. A review of Resident #4's individualized care plan (CP) reflected the resident used antipsychotic medication (med) Seroquel related to (r/t) psychosis with the following intervention of Monitor/record for target behaviors (hitting, kicking, scratching, grabbing, yelling, screaming, insomnia, hallucinations, restlessness, delusions, interference with care, throwing objects, paranoia, etc The CP also reflected that the resident had potential to be physically and/or verbally aggressive r/t increased anxiety. A review of Resident #4's December 2025 electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) indicated the resident was prescribed the following antipsychotic med:Seroquel oral tablet (tab), give 12.5 mg (milligram) by mouth at bedtime (HS) for schizoaffective disorder.Further review indicated the following order:BEHAVIORS - MONITOR FOR THE FOLLOWING: () RESTLESSNESS (AGITATION), HITTING, INCREASE IN COMPLAINTS, SPITTING, CUSSING, RACIAL SLURS, ELOPEMENT, PSYCHOSIS, AGRESSION, REFUSING CARE. Document: 'N' if none of the above observed. 'Y' if any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings every shift. A review of the Nurses' documentation indicated check marks for each shift for each day. The Nurses' did not indicate a Y or N to reflect if the resident had a behavior and what the behavior was. A review of Resident #4's Psych (Psychiatric) follow up note dated 12/24/25, included the following but was not limited to: .was getting paranoid and psychotic started on Seroquel with good effect. Difficult to tell if schizoaffective disorder or in the context of delirium, will try to reduce dose and observe.recommendation: reduce Seroquel to 12.5 mg every HS for now and observe for reemergence of psychosis. On 12/30/25 at 10:56 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding antipsychotic medications (meds) and behavior monitoring. The LPN stated there was an order for behavior monitoring each shift in the computer and that it had a yes or a no. The LPN stated that if there was a behavior observed then the nurse would put a yes and document what the behavior was in the PN (Progress Notes). The LPN stated that if there was no behavior then the nurse would put a no and there would not be a PN. The surveyor asked the LPN if anyone did a monthly recap of how many behaviors the resident had. The LPN stated maybe the unit manager did. On 12/30/25 at 11:30 AM, the surveyor interviewed the third floor Unit Manager (TFUM) regarding 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
	315526	A. Building B. Wing	01/05/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	process of antipsychotic med and behavior monitoring. The TFUM stated that there was an order in the eMAR for behavior monitoring every shift and the nurse would indicate yes or no. The TFUM stated that if there was a behavior observed then the nurse would put a yes and there should be a PN to describe the behavior. The TFUM stated that she was not sure if a monthly recap of how many behaviors was done. She added that the nurse would let her know if there was an increase in behaviors and then she would notify the psychiatrist. The surveyor asked the TFUM to view Resident #4's December 2025 eMAR. On 12/30/25 at 11:39 AM, the TFUM stated that there should be a yes or no for Resident #4 for the order of behavior monitoring and not check marks. On 12/31/25 at 9:51 AM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) regarding antipsychotic med and behavior monitoring. The ADON/IP stated that there was a specific order for behavior monitoring and the nurse should document a yes or no. The surveyor showed the ADON/IP Resident #4's behavior monitoring order on the eMAR that had only check marks on it and not the ordered yes or no. The ADON/IP stated it should not be like that. On 1/2/26 at1:20 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and ADON/IP the concerns that Resident #4's behavior monitoring order documentation did not indicate if the resident had behaviors or did not have behaviors since there were only check marks and not the ordered yes or no. On 1/5/26 at 11:03 AM, in the presence of the LNHA, ADON/IP, and Nurse Consultant (NC), the DON stated that the order was put in wrong by the supervisor. The DON stated that it was corrected after surveyor inquiry. 2. On 12/29/25 at 10:02 AM, the surveyor observed Resident #9 sleeping in bed with floor mats on both sides of the bed. A review of Resident #9's AR reflected that the resident was admitted to the facility with diagnoses which included, but not limited to; unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, schizoaffective disorder and unspecified visual loss. A review of Resident #9's most recent quarterly MDS reflected that the resident's cognitive skills for daily decision making was severely impaired. Further review indicated that the resident was taking or had taken in the last seven days or since admission/entry or readmission an antipsychotic med and that it was received on a routine basis. A review of Resident #9's individualized CP reflected the resident had potential to be physically and/or verbally aggressive r/t psychosis. The CP also reflected that the resident used antipsychotic med related to mood disorder/psychotic disturbances accompanied by visual hallucinations at times. A review of Resident #9's December 2025 eMAR and eTAR indicated the resident was prescribed the following antipsychotic med:Depakote Sprinkles Oral Capsule (cap) Delayed Release Sprinkle 125 mg, give 1 cap by mouth one time a day for mood disturbance.Depakote Sprinkles Oral Cap Delayed Release Sprinkle 125 mg, give 2 capsules (caps) by mouth two times a day for Mood Disorder 2 caps equal a total of 250 mg.Further review indicated the following order:BEHAVIORS - MONITOR FOR THE FOLLOWING: () RESTLESSNESS (AGITATION), HITTING, INCREASE IN COMPLAINTS, SPITTING, CUSSING, RACIAL SLURS, ELOPEMENT, PSYCHOSIS, AGRESSION, REFUSING CARE. Document: 'N' if none of the above observed. 'Y' if any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings every shift.Further review indicated that on the day shift of 12/1/25, 12/4/25, 12/10/25, 12/13/25, and 12/19/25, the nurse wrote yes that Resident #9 had a behavior observed. A review of Resident #9's PN for those dates indicated a PN that a behavior was observed but there was no documentation regarding what the behavior was. A review of Resident #9's Psych follow up note dated 12/24/25 included the following but was not limited to: resident on hospice with functional and cognitive decline.was getting very paranoid needed Seroquel.now getting more anxious managed by lorazepam will try to DC (discontinue) seroquel and monitor psychosis.diagnosis: moderate dementia with behavioral disturbances.recommendation: continue depakote 250 mg bid (twice a day) and 125 qd (once a day). DC seroquel, discussed with Hospice team observe for reemergence of paranoia and psychosis. On 12/30/25 at 11:30 AM, the surveyor interviewed the TFUM regarding the process of antipsychotic med and behavior monitoring. The TFUM stated that there was an order in 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
	315526	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livingston Post Acute Care	348 E Cedar Street Livingston, NJ 07039

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	electronic eMAR for behavior monitoring every shift and the nurse would indicate yes or no. The TFUM stated that if there was a behavior observed then the nurse would put a yes and there should be a PN to describe the behavior. The TFUM stated that she was not sure if a monthly recap of how many behaviors was done. She added that the nurse would let her know if there was an increase in behaviors and then she would notify the psychiatrist. On 12/30/25 at 11:46 AM, the surveyor asked the TFUM to view Resident #9's December 2025 eMAR and PN. The TFUM confirmed that there was not any documentation of what the behavior was observed in the PN. The TFUM stated that she would expect a note about what the behavior was if there was a yes on the eMAR. On 12/31/25 at 9:51 AM, the surveyor interviewed the ADON/IP regarding antipsychotic med and behavior monitoring. The ADON/IP stated that there was a specific order for behavior monitoring and the nurse should document a yes or no. She added that there should be documentation to what the behavior was that was observed. The surveyor showed the ADON/IP Resident #9's behavior monitoring order on the MAR with the yes and that there was no documentation in the PN as to what the behavior was. The ADON/IP stated it should not be like that. On 1/2/26 at1:20 PM, the surveyor notified the LNHA, DON and ADON/IP the concern that Resident #9's behavior monitoring order documentation did indicate a yes or no that the resident had a behavior or not but that it did not indicate what the behavior was that occurred or how many episodes of the behavior in the PN. On 1/5/26 at 10:59 AM, in the presence of the LNHA, DON and NC, the ADON/IP stated that Resident #9's CP showed the resident's behavior. She added that if anything outside the behavior of the CP would have been documented in the PN. A review of the facility's Antipsychotic Medication Use Policy revised July 2022, included the following:Policy StatementResidents will not receive meds that are not clinically indicated to treat a specific condition. Antipsychotic meds will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review.Policy Interpretation and Implementation1. Residents will only receive antipsychotic meds when necessary to treat specific conditions for which they are indicated and effective.17. The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic meds.A review of the undated facility's Behavioral Assessment, Intervention and Monitoring Policy included the following:Policy Statement1. The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.6. The facility will comply with regulatory requirements related to the use of meds to manage behavioral changes.Policy Interpretation and ImplementationAssessment3. The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition, including:a. onset, duration, intensity and frequency of behavioral symptoms;.Monitoring1. If the resident is being treated for altered behavior or mood, the IDT (interdisciplinary team) will seek and document any improvements or worsening in the individual's behavior, mood, and function.The LNHA did not provide any additional information.N.J.A.C. 8:39-4.1(a)6; 27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. REPEAT DEFICIENCYBased on observation, interview, and record review, it was determined that the facility failed to maintain professional standards of nursing practice for not following physician orders for 2 of 29 residents reviewed, Resident #1 and Resident #4.The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1.On 12/29/25 at 11:22 AM, Surveyor #1 (S #1) observed Resident #1 in their room with the Certified Nursing Assistant (CNA) provided care. The resident was not available for an interview. At that time, S #1 interviewed the second floor License Practical Nurse/Charge Nurse (LPN/CN), who stated that the resident was on a bolus Tube Feeding (TF) 4x/day (four times a day) and on an oral full liquid diet. On 12/30/25 at 2:02 PM, S #1 reviewed the medical records for Resident #1 which revealed the following: A review of the admission Record (AR; an admission summary) reflected diagnosis not limited to; dysphagia oropharyngeal phase (difficulty swallowing and moving food from mouth to the throat), dysphagia pharyngoesophageal phase (difficulty swallowing and moving food from the throat to the esophagus), and esophageal obstruction. A review of the comprehensive Minimum Data Set (cMDS), an assessment tool to facilitate the plan of care, with an assessment reference date (ARD) of 12/7/25, reflected a Brief Interview Mental Status (BIMS) score of 14 out of 15 indicating intact cognition. The MDS revealed the resident was dependent for eating, on a mechanical altered diet and a TF. A review of the resident's care plan (CP) reflected, the resident required TF related to (r/t) dysphagia, date initiated 10/9/25. A review of the physician order (PO) summary and the electronic Medication Administration Record (eMAR) for December 2025, revealed the following: -Ordered on 12/18/25, Gabapentin oral tablet (tab) 400 mg (milligram), give 1 tab by mouth two times a day for pain. (Administered 12/18/25 through 12/31/25 for 14 days total). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livingston Post Acute Care	348 E Cedar Street Livingston, NJ 07039

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ordered on 11/30/25, Acetaminophen (Tylenol) Tab 325 mg, give 2 tablets (tabs) by mouth every 6 hours as needed (PRN) for temp (temperature) greater than or equal to 100 degrees F (fahrenheit) do not exceed 3 gm (grams) of acetaminophen from all sources in 24 hrs (hours) 2 tabs = 650 mg; administered on 12/2/25 at 11:56 AM. -Ordered on 11/30/25, Tylenol tab 325 mg, give 2 tabs by mouth every 6 hours PRN for pain do not exceed 3 gm of Acetaminophen from all sources in 24 hrs.2 tabs = 650 mg; Administered on 12/1/25 at 8:12 AM. -Ordered on 12/1/25, four times a day for Nutrition Enteral feeding orders: Formula: Vital 1.5 Route: via GT (gastrostomy tube, a feeding tube from the abdomen through the stomach for nutrition) Administer 237 ml (milliliters) x 4 per day, for TF TV (total volume) 948 mls/day, for 1420 cals/day (calories/day). -Ordered on 12/2/25, full liquid diet liquid texture, 0 - Thin Liquid consistency, for full liquid diet. A review of the Registered Dietician's re-admission progress note (PN) dated 12/4/2025, reflected a diagnoses of difficulty swallowing, esophageal stricture and diet ordered for full liquid, thin, with TF. On 12/31/25 at11:04 AM, S #1 interviewed the Registered Nurse (RN). The surveyor asked about the above concerns with PO with TF and the medications (meds) Tylenol and Gabapentin which were ordered orally and how the RN administered them, and the RN replied that she crushed the Gabapentin and Tylenol, and mixed with water and administered via GT because the resident was unable to swallow. The RN confirmed it was ordered to administer by mouth the meds Tylenol and Gabapentin. S #1 asked the RN if there was an order to crush the meds and instill in GT and she confirmed No. On 12/31/25 at 11:24 AM, S #1 interviewed the second floor LPN/CN, who confirmed that the above orders by mouth versus via GT should had been clarified. On 1/5/26 at 11:27 AM, S #1 notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant DON (ADON), and the Nurse Consultant (NC) regarding the above concerns with Tylenol and Gabapentin, for not following PO and not clarifying the orders. On 1/5/26 at 1:19 PM, the LNHA informed S #1 that no additional information was provided. A review of the facility's Administering Medications Policy dated 5/2025, revealed under Policy Interpretation and Implementation #4. Meds are administered in accordance with prescriber orders, including any required time frame #8. If a dosage is believed to be inappropriate .the person preparing or administering the medication (med) will contact the prescriber, the resident's attending physician to discuss the concerns . 2. On 12/29/25 at 10:35 AM, Surveyor #2 (S #2) observed Resident #4 seated on a couch in their room. S #2 did not observe any devices between the resident's legs. On 12/30/25 at 11:13 AM, S #2 observed Resident #4 seated on a couch with their one leg crossed over their other leg. S #2 did not observe any devices between the resident's legs. A review of Resident #4's AR reflected that the resident was admitted to the facility with diagnoses which included, but not limited to; fracture of neck of right femur (a type of hip fracture, broken bone), (continued on next page)

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	315526	A. Building B. Wing	01/05/2026

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Livingston Post Acute Care	348 E Cedar Street Livingston, NJ 07039

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unspecified dementia with other behavioral disturbance (a form of dementia where the underlying cause is unknown, and the individual experiences a range of behavioral and psychological changes beyond the typical memory and cognitive decline associated with dementia), and anemia (problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). A review of Resident #4's most recent cMDS, reflected that the resident had a BIMS score of 8 out of 15, which indicated that Resident #4's cognition was moderately impaired. On 12/30/25 at 9:10 AM, S #2 reviewed Resident #4's December 2025 eMAR and electronic Treatment Administration Record (eTAR) which included the following order: Place abduction pillow in between legs when in bed and in chair every shift for Hip fx (fracture). The nurses for each shift of each day signed the eMAR with a check mark to indicate the abduction pillow was placed each shift from 12/1/25 through 12/29/25. Further review of the December 2025 eMAR and eTAR included the following orders: Anticoagulant Medication (med)- MONITOR FOR DISCOLORED URINE, BLACK TARRY STOOLS, SUDDEN SEVERE HEADACHE, N&V, DIARRHEA, MUSCLE JOINT PAIN, LETHARGY, BRUISING, SUDDEN CHANGES IN MENTAL STATUS AND/ OR V/S (vital sign), SOB (shortness of breath), NOSE BLEEDS. Document: 'N' if none of the above observed. 'Y' if any of the above was observed, select chart code 'Other/ See Nurses Notes' and PN findings every shift for enoxaparin use. ANTIDEPRESSANT MED - MONITOR FOR SEDATION, DROWSINESS, DRY MOUTH, BLURRED VISION, URINARY RETENTION . Document: 'N' if none of the above observed. 'Y' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and PN findings every shift. ANTIPSYCHOTIC Med -MONITOR FOR DRY MOUTH, CONSTIPATION, BLURRED VISION, DISORIENTATION/CONFUSION, DIFFICULTY URINATING, HYPOTENSION, DARK URINE, YELLOW SKIN, N/V, LETHARGY, DROOLING Document: 'N' if none of the above observed. 'Y' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and PN findings every shift for Quetiapine & olanzapine use. The nurses for each shift for each day signed with a check mark and not the ordered yes or no for each of the side effect monitoring orders. On 12/30/25 at 10:56 AM, S #2 interviewed the Licensed Practical Nurse (LPN) regarding side effect monitoring for meds. The LPN stated there was an order for side effect monitoring each shift in the computer and that it had a yes or a no. S #2 then asked the LPN about Resident #4 and if the resident used an abduction pillow. The LPN stated that the resident had a right hip fracture and when the resident returned to the facility after surgery, was on another unit. She added that the resident had an abduction pillow but that when they were transferred to this unit they did not use it anymore. S #2 asked the LPN to view the resident's December eMAR and eTAR. The LPN confirmed there was an order for abduction pillow and she stated that maybe they should have taken off the order, and that the resident did not use it anymore. On 12/30/25 at 11:30 AM, S #2 interviewed the third floor Unit Manager (TFUM) regarding the process for side effect monitoring. The TFUM stated that there was an order for side effect monitoring in 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
	315526	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	computer and that the nurse would document yes or no. S #2 asked the TFUM to view Resident #4's December 2025 eMAR and eTAR. The TFUM stated that there should be a yes or no for Resident #4 for the orders of side effect monitoring and not check marks. On 12/30/25 at 11:35 AM, S #2 interviewed the TFUM regarding Resident #4's abduction pillow. The TFUM stated that the resident came to the unit about a month ago and that the resident used the abduction on the other unit but that it was not used on this unit. S #2 asked the TFUM to view Resident #4's December 2025 eMAR and eTAR. The TFUM confirmed that the order should have been discontinued (d/c'd) for the abduction pillow. On 12/31/25 at 9:51 AM, S #2 interviewed the ADON regarding side effect monitoring for meds. The ADON stated that there was a specific order for side effect monitoring for each med that required it and the nurse should document a yes or no. S #2 showed the ADON Resident #4's side effect monitoring orders on the eMAR. The ADON stated it should not be like that. S #2 asked the ADON if Resident #4 was not using the abduction pillow should the nurses be signing it as given. The ADON stated that the nurses should have told the doctor and d/c'd the order. On 1/2/26 at1:20 PM, S #2 notified the LNHA, DON, and ADON the concerns that Resident #4 had an order for abduction pillow between legs when in bed and in chair and that S #2 did not observe the pillow and the staff were signing that the order was administered and that the PO for side effect monitoring for several meds were not being followed with a yes or no. On 1/5/26 at 11:03 AM, in the presence of the LNHA, ADON, and NC, the DON stated that the abduction pillow was ordered on 10/15/25, and d/c'd on 12/30/25. S #2 asked if it was d/c'd after surveyor inquiry. The ADON stated yes. The ADON further stated that Resident #4 had a CP for being non compliant. S #2 asked the ADON if the resident was not compliant with the abduction pillow should the physician have been notified for further orders. The ADON stated that the expectation would have been to call the doctor. The DON stated that in regards to the side effect monitoring the order part for yes or no was put in wrong by the supervisor and that it had been corrected after surveyor inquiry. The LNHA did not provide any additional information. A review of the facility Psychotropic Medication Use Policy dated July 2022, included the following: 13. Residents receiving psychotropic meds are monitored for adverse consequences. NJAC 8:39 27.1(a),29.2(d)

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	315526	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that resident receive treatment and care in accordance with professional standards of practice, by failing to ensure; a.) a physician's order (PO) was transcribed for acute transfer to hospital, b.) the PO for supplement was followed, and c.) the provider's assessment and plan was followed through and clarified for 1 of 29 residents (Resident #166) reviewed.This deficient practice was evidenced by the following:Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 12/30/25 at 8:34 AM, the surveyor reviewed the medical records of Resident # 166, and revealed: A review of the admission Record or face sheet (an admission summary) reflected that Resident #166 was admitted to the facility with medical diagnoses which included but not limited to; altered mental status unspecified, essential hypertension (elevated blood pressure), type 2 diabetes mellitus without complications, unspecified protein calorie malnutrition, and dysphagia (difficulty swallowing food or liquids) oral phase. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, with an assessment reference date of 11/14/25, with a brief interview for mental status (BIMS) score of 13 out of 15, reflected that the resident's cognition was intact. Further review of the MDS revealed a discharge return anticipated assessment was done. Section A (Identification Information) of the MDS reflected that the resident had an unplanned transfer to hospital. A review of the Progress Notes (PN) that was electronically signed by the Nurse Practitioner (NP) revealed a Late Entry Notes, with an effective dates on 11/30/25 (created on 12/5/25), 11/25/25 (created 11/29/25), 11/22/25 (created 11/29/25), and 11/20/25 (created 11/29/25), with assessment/plan that reflected, post treatment labs (laboratory) scheduled on 11/24, not drawn, and still waiting to be drawn. Further review of the PN revealed there was no documented evidence that the nurse responded to the assessment/plan and as to why it was not followed. A review of the PN with an effective date of 12/1/25 at 6:36 AM, that was electronically signed by the Registered Nurse (RN), reflected that Resident #166 was transferred to the hospital related to change to status/unstable vitals (objective measurements of the body's most basic, essential functions (temperature, pulse, respiration, blood pressure) used by healthcare providers to assess physical functioning, detect problems, and monitor health status, acting as a crucial first step in any medical evaluation to gauge overall health and urgency) and per NP, the resident need to be sent out, and the resident representative (RR) was notified. A review of the November and December 2025 Order Summary Reports (OSR) included the following but were not limited to:-Glucerna two times a day for nutrition, give 237 ml/8 oz (milliliters/ounces) by <(INDICATE ROUTE)>record in percentage as follows: 1=0-25% 2=26-50% 3=51-75% 4=76-100% shake well, order date 11/15/25. The above order for Glucerna was discontinued on 12/1/25. Further review of the above order for Glucerna revealed that there were no record in percentage of the amount taken according to the PO for November 2025. In addition, there was no documented evidence that there was a PO for transfer to hospital that was transcribed in the OSR. On 1/2/26 at 10:11 AM, the surveyor interviewed the Director of Nursing (DON) in 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
	315526	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livingston Post Acute Care	348 E Cedar Street Livingston, NJ 07039

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	presence of the Licensed Nursing Home (LNHA), and Assistant Director of Nursing (ADON). The DON stated that as the facility's practice, the physician or NP would visit the resident in LTC (Long Term Care) once a month, SAR (subacute rehab) minimally once a week. He also stated that different doctors had different ways and communicate any changes to any nurses. The DON also added that if there were something to be followed up, the nurse had to document in the PN. The ADON also confirmed that it was an expectation that communication between NP and nurse included follow through would be documented in the PN. On that same date and time, the DON stated that the expectation was to include the amount according to the PO of the supplement. The surveyor notified the concern that the resident had no transfer order to the hospital. The DON stated there should be an order when the resident was being transferred to the hospital. The ADON also confirmed that there should be an PO for acute transfer to the hospital. The surveyor also notified the concern with Glucerna, the DON confirmed that the nurse should followed the order, and the ADON stated that it should reflect the amount in the electronic Medication Administration Record (eMAR). The surveyor also notified the concern about NP's PN that included assessment/plan about labs for 11/24, that was not drawn and awaiting to be drawn for the late entries PN. The surveyor also added that there were no documented evidence by the nurse as to why it was not followed. Both the LNHA and DON stated you mean copy and paste notes. On 1/2/26 at 10:46 AM, the Nurse Consultant (NC) informed the surveyor that she checked the NP's notes, and all were late entry notes. The NC (also known as the Regional Nurse) stated that the PN were copy and paste notes. The NC also stated that the facility management would talk to the NP about her PN. On 1/2/26 at 1:20 PM, the survey team met with the LNHA, DON, and ADON. The surveyor notified the above concern with Resident #166 with regard to no transfer order to hospital, not following physician order for Glucerna, and the NP's PN. On 1/5/26 at 11:11 AM, the survey team met with the LNHA, DON, NC, and ADON. The ADON informed the surveyors that Resident #166 got the Glucerna but unable to document the amount, and that was fixed after the surveyor's inquiry. On that same date and time, the NC stated that the NP did not order any labs and were late entry documents. She further stated that the note where the NP was going to order the labs for the 24th was not documented until the 29. She added that no labs ever ordered by the NP. The ADON stated that they reached out to the MD (Medical Doctor) to inform him of such. On 1/5/26 at 1:19 PM, the LNHA informed the survey team that there were no further information to provide, and the survey team could proceed with decision making. NJAC 8:39-3.2(a,b); 11.2(b); 27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Repeat Deficiency Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to ensure the necessary respiratory care and services of residents that were receiving oxygen, according to the standard of clinical practice and the facility's policy and procedure, specifically, having a valid physicians' order and by documenting the date and time the oxygen tubing was changed for 1 of 1 resident, Resident #74. This deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On 12/29/25 at 11:51 AM, during the initial tour of the facility, the surveyor observed Resident #74 sitting in a wheelchair (w/c) receiving oxygen (O2) by nasal cannula (NC; a tube that delivers O2 to the nasal passages). The surveyor observed the tubing the resident was currently using, attached to a wall O2 mount and there were no any labels on the O2 tubing to denote when the tubing was applied or last changed. The surveyor observed a second set of O2 tubing lying on the resident's bed and was attached to an O2 tank on the back of the w/c. The surveyor did not observe any labels denoting when the tubing was applied or last changed. The surveyor observed that tubing and NC that was not currently in use was not contained in a bag or other container but was lying open on the resident's bed sheets. On 12/31/25 at 11:02 AM, the surveyor observed staff brought O2 tubing into the resident's room in a new package.On 12/31/25 at 11:21 AM the surveyor interviewed the Assistant Director of Nursing (ADON) and asked if a resident was on O2, should there be a physicians' order (PO). The ADON stated yes, other than in an emergency, a PO was required. The surveyor asked if the tubing was changed regularly and documented when it was, and the ADON stated the tubing was usually changed on Wednesdays and the PO would have that as part of the order. The surveyor asked if O2 should be part of the residents' Care Plan (CP). The ADON stated yes it should be included at the start or if added a revision was done.The surveyor reviewed the electronic medical record (eMR) for Resident #74. A review of the Order Summary Report (OSR) did not reflect any PO for O2.A review of the resident's CP, did not include information or documentation that the resident was receiving continuous O2.A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) date of 12/14/25, revealed under Section O, respiratory treatments, that the resident was receiving continuous O2.On 12/31/25 at 12:00 PM, the surveyor interviewed the Director of Nursing (DON). The DON stated yes, the orders should have the date and frequency when it should be changed, usually Wednesdays, the tubing should be dated and put in a clean bag when not in use. On 01/5/26 at 10:55 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, ADON and Nurse Consultant, and the DON stated that the O2 should have a PO and be in the CP. The LNHA did not provide any further pertinent information. A review of the facility's Oxygen Administration Policy, dated updated 4/2025, reflected, under Preparation: 1. Verify there is a PO for this procedure.2. Review the resident's care plan.A review of the facility's Care Plans, Comprehensive Person Centered Policy, dated 5/2025, reflected under 6.b.services that are to be furnished to attain or maintain the resident's highest practicable (continued on next page)

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	315526	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physical.well-being. e. reflects currently recognized standards of practice for problem areas and conditions .10. The interdisciplinary team reviews and updates the CP. NJAC 8:39-11.2(b); 27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. Building B. Wing	01/05/2026

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure that the resident did not receive an unnecessary medication by excessive dose for 1 of 5 residents reviewed for unnecessary medications, (Resident #7). The deficient practice was evidenced by the following: The surveyor reviewed Resident #7's electronic medical record (EMR) which revealed the following.A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included, essential hypertension (high blood pressure), pain due to internal orthopedic implants, and muscle weakness.A review of Resident #7's Comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 11/25/25, had a Brief Interview Mental Status (BIMS) score of 13 out of 15, which indicated the resident has no cognitive impairment.A review of the resident's Physician orders (PO) revealed an Order Summary Report (OSR), which reflected the following orders:-Lidocan External Patch (Lidocaine), apply to remove topically at bedtime (HS) for remove and remove per schedule. Dated 11/23/25.-Lidocaine Pain Relief 4 % Patch, apply to right shoulder topically one time a day for pain management and remove per schedule. Dated 11/23/25. A review of the resident's electronic medication administration (eMAR) revealed the following orders: Lidocan External Patch, apply to remove topically at HS for remove and remove per schedule-Order Date-11/23/2025, with administration times of: remove 2059 (8:59 PM), apply 2100 (9:00 PM). The eMAR reflected administration dates of 12/1/25 through 12/28/25 as being administered to the resident.The eMAR did not reflect the order: Lidocaine Pain Relief 4 % patch, apply to right shoulder topically one time a day for pain management and remove per schedule.A review of the resident's Progress Notes (PN) revealed a PN titled Physician H&P (History and Physical) dated 10/3/25. This PN reflected medications (meds): Lidocaine patch to lower back. The PN did not reflect any dose or timing.A review of the drug label information for lidocaine 4% patch reflected the following information: Directions for Adults and children [AGE] years of age and over to apply 1 patch at a time to affected area; not more than 3 to 4 times daily, and remove patch from the skin after at most 8-hour application.On 12/31/25 at 11:24 AM, the surveyor interviewed the Assistant Director of Nursing (ADON). The surveyor asked the ADON if they were familiar with Lidocaine or Lidoderm patches and how they were used or applied, and the ADON stated yes, they should be on for 8 or 12 hours then removed depending on the order.On 1/5/26 at 9:11 AM, the surveyor interviewed the facility Consultant Pharmacist (CP). The surveyor asked the CP if they were familiar with Lidocaine 4% patches and how they were used. The CP stated yes, they should be applied for no more than 8 to 12 hours depending on the product then removed and not re-applied for another 12 hours. The surveyor asked if they should be applied 24 hours, and a new patch applied right after removal. The CP stated no, they should not be applied for 24 hours continuously.The LNHA did not provide any further pertinent information. NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livingston Post Acute Care	348 E Cedar Street Livingston, NJ 07039

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications (meds) were administered without error of 5% or more during medication (med) administration, 3 nurses administered meds to 3 residents. There were 25 opportunities for error, 6 errors were observed which calculated to a med administration error rate of 24%. This deficient practice was identified for 2 of 3 residents, (Resident #139, and Resident #83), that was administered meds by 2 of 3 nurses that were observed. The deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On 12/30/25 at 8:33 AM, the surveyor observed the Licensed Practical Nurse (LPN) prepare meds for Resident #139. The meds included an active physician's order (PO) for aspirin tablet (tab) delayed release 81 mg (milligram) (ASA 81 mg DR), give 1 tab by mouth one time a day for CAD (coronary artery disease).The surveyor observed the LPN prepared and administered Resident #139's meds which included one aspirin tab 81 mg chewable tab (ASA 81 mg Chew). The surveyor then observed the LPN administer the ASA 81mg Chew, along with other due meds to the resident. Upon return to the medication cart (med-cart), the surveyor asked the LPN to identify the bottle she took the aspirin from. The LPN showed the surveyor the bottle labeled aspirin tab 81 mg chewable tab. The surveyor asked the LPN to compare the bottle label to the order on the resident's electronic medication administration record (eMAR). The LPN stated that it should have been the aspirin tab DR 81 mg. The surveyor observed that there was a bottle of ASA 81 mg DR in the med-cart. On the same date, beginning at 9:06 AM, the surveyor observed the Registered Nurse (RN) prepare to administer meds to Resident #83. The surveyor observed the following active PO's on the resident's eMAR:Aspirin oral tab chewable 81 mg, give 1 tab by mouth one time a day for CAD. (ASA 81 mg Chew) ordered to be given at 9:00 AM. Insulin aspart subcutaneous (SQ) solution pen-injector 100 unit/ml Inject as per sliding scale: if 0 - 149 = 0 unit SQ;150 - 200 = 2 units SQ;201 - 250 = 4 units SQ;251 - 300 = 6 units SQ;301 - 350 = 8 units SQ;351 - 400 = 10 units SQCall MD (medical doctor) for BS (blood sugar) result 350 or more, SQ four times a day for DM (diabetes mellitus). Ordered to be given at 7:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM.DuLoxetine HCl (hydrocholoride) capsule (cap) DR (delayed release) particles 30 mg, give 1 cap by mouth one time a day for depression. Ordered to be given at 9:00 AM.Folic acid tab 1 mg, give 1 tab by mouth one time a day for Supplement. Ordered to be given at 9:00 AM.Insulin Glargine-Subcutaneous solution pen injector 100 unit/ml Inject 10 unit SQ one time a day for DM/ Hyperglycemia. Ordered to be given at 9:00 AM.Oxycodone HCl ER (extended release) tab 12 hour Abuse-Deterrent 10 mg, give 1 tab by mouth every 12 hours for moderate to severe pain. Ordered to be given at 8:00 AM. During the observation, the RN could not locate the resident's folic acid or duloxetine. The surveyor observed the RN document not in cart and not prepare those meds. At this time, the RN stated that they could not locate the resident's insulin glargine, and it must be in the refrigerator, The RN then proceeded into the resident's room, placed the meds on the resident's tray table and inform the resident that they had to go get the insulin. The RN then left the room. The surveyor remained to observe the resident, who took the meds that were left on the table. (continued on next page)

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	315526	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor asked the resident if the nurses always leave meds on the table. The resident responded with a shrug and said sometimes. The RN returned with the insulin glargine, which they administered to the resident with the insulin aspart.Afterward, the surveyor asked the RN should meds be left at the resident's bedside, and the RN stated no, they really should not be. The surveyor asked if it was common practice to not give meds, folic acid and duloxetine, if they were not found in the cart, and the RN stated, sometimes we check the backup meds. The surveyor also asked if meds be given as the PO them and on time, and the RN stated yes, they should be given per the doctors' orders. The surveyor notified the RN about the late oxycodone and the insulin aspart, and the RN stated that they like to wait for the resident to eat before giving insulin.Furthermore, the surveyor asked the RN to see the bottle they used for the aspirin and compare it to the eMAR. The surveyor notified the RN that the order was for ASA 81 mg chewable and RN gave ASA 81 mg DR.The surveyor concluded the med pass.The surveyor reviewed Resident #139's electronic medical record (eMR). The eMR revealed an OSR that reflected that the resident had an active order for aspirin tab DR 81 mg scheduled for 9:00 AM. The eMR also revealed an eMAR that reflected the same order.The surveyor reviewed the EMR for resident #83, and revealed an OSR that reflected the following orders:Folic acid tab 1 mg, give 1 tab by mouth one time a day for supplement.Insulin Glargine SQ Solution Peninjector100 unit/ml, inject 10 unit SQ one time a day for DM/Hyperglycemia.Aspirin oral tab chewable 81 mg, give 1 tab by mouth one time a day for CAD.DULoxetine HCl cap DR particles 30 mg, give 1 cap by mouth one time a day for depression.Insulin Aspart SQ Solution Pen-injector 100 unit/ml, inject as per sliding scale: if 0 - 149 = 0 unit SQ;150 - 200 = 2 units SQ;201 - 250 = 4 units SQ; 251 - 300 = 6 units SQ; 301 -350 = 8 units SQ; 351 - 400 = 10 units SQ Call MD for BS result 350 or more, SQ four times a day for DM. OxyCODONE HCl ER tab 12 Hour Abuse-Deterrent 10 mg, give 1 tab by mouth every 12 hours for moderate to severe pain.The eMR also revealed an eMAR that reflected those same orders with the order for Oxycodone ER scheduled for 8:00 AM, the insulin aspart scheduled for 7:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM. The remainder of the above-mentioned orders were scheduled for 9:00 AM. On 12/31/25 at 12:00 PM, the surveyor discussed concerns with the med-pass with the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA). The surveyor asked the DON if the nurses should leave meds at the resident's bedside if they were not self-administering. The DON stated no, they should not. The surveyor asked if the nurses should always follow the physician's med orders for med accuracy and timing unless otherwise instructed by the physician. The DON stated yes, they should always follow the med orders. The surveyor asked if the nurses should just not give meds if they could not find them. The DON stated no, they should follow the policy for missing meds and call the physician if the meds were not located.On 1/5/26 at 9:11 AM, the surveyor interviewed the facility Consultant Pharmacist (CP) by phone. The surveyor asked the CP if the staff should administer meds per PO. The CP stated yes, the staff should always follow the PO. The surveyor asked what the nurse should do if the med was not available in the med-cart. The CP stated that the nurse should follow facility policy and check if there was a backup supply and if not call the doctor for instructions. The surveyor asked if the nurse should leave meds unattended at the resident's bedside. The CP stated no, meds should not be left unattended, the nurse should witness the resident take them.On 1/5/26 at 10:55 AM, the surveyor met with the LNHA, DON, Assistant Director of Nursing (ADON) and Nurse Consultant (NC), and the LNHA stated that the RN that was observed on med-pass was suspended and will require further education. The NC stated that the residents' physicians were called and informed of the errors.The LNHA provided no further pertinent information.A review of the facility's Administering Medications Policy, dated updated 5/2025, reflected under 4. Meds are administered in accordance with prescriber orders, including any required time frame .7. Meds are administered within one (1) hour of their prescribed time, unless otherwise specified.A review of the facility's Unavailable Medication Policy', dated June 2021, reflected under 2. In the event that a med ordered for a resident is noted to be unavailable.nursing staff shall: b. Attempt to obtain.from the.automated med dispensing system.c. Notify the physician.i. Obtain a new order.ii. Obtain a hold order. N.J.A.C 8:39-29.2 (d)

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	315526	A. Building B. Wing	01/05/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, it was determined that the facility failed to a.) provide pharmaceutical services by ensuring the accurate administration of a medication (med) Midodrine, with a parameter according to the physician's order to meet the needs of the resident for 1 of 2 residents, (Resident #1) reviewed for med management and b.) ensure that residents were free from any significant med errors for 1 of 3 residents (Resident #83) during the med pass observation, in accordance with professional standards clinical practice. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1.On 12/29/25 at 11:22 AM, Surveyor #1 (S #1) observed Resident #1 in their room with a Certified Nursing Assistant (CNA) provided morning care. The resident was unavailable for an interview. On 12/30/25 at 2:02 PM, S #1 reviewed the electronic medical records (EMR) of Resident #1. A review of the admission Record (an admission summary) revealed that Resident #1 had diagnoses that included but were not limited to encounter for other orthopedic aftercare, fracture of unspecified part of neck of left femur, displaced intertrochanteric fracture of right femur, and hypotension. A review of the comprehensive Minimum Data Set (MDS), an assessment that facilitate the management of care, with an assessment reference date (ARD) of 12/7/25, reflected a Brief Interview of Mental Status (BIMS) score of 14 out of 15, indicated that the resident had intact cognition. A review of the physician's order (PO) dated 12/2/25, revealed Midodrine HCl (hydrocholoride) oral tablet (tab) 5 mg (milligram), give 1 tab via G-Tube (gastrostomy tube-a feeding tube from the abdomen to the stomach to deliver nutrition, fluids and medications) three times a day for low blood pressure. Hold for Systolic Blood Pressure (SBP-top number in a blood pressure reading) greater than 120 mm/hg (millimeters of mercury) . A review of the December 2025 electronic Medication Administration Record (eMAR) revealed the Midodrine was administered outside the parameters on the following dates: 12/2/25 with B/P (blood pressure) of 128/88 at 5:00 PM12/14/25 with B/P of 128/66 at 1:00 PM12/14/25 with B/P of 124/70 at 5:00 PM12/22/25 with B/P of 125/68 at 5:00PM12/26/25 with (continued on next page)

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	315526	A. Building B. Wing	01/05/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B/P of 143/83 at 1:00 PM12/27/25 with B/P of 129/74 at 5:00 PM12/28/25 with B/P of 130/70 at 5:00 PM Further review of the eMAR revealed Midodrine was withheld on these dates, with no B/P written on the eMAR. The eMAR had a documentation of an X instead of an actual B/P: 12/5/25 at 1:00 PM12/8/25 at 9:00 AM, 1:00 PM and 5:00 PM12/9/25 at 9:00 AM and 5:00 PM12/11/25 at 9:00 AM and 5:00 PM12/12/25 at 9:00 AM and 5:00 PM12/14/25 at 9:00 AM12/16/25 at 9:00 AM and 5:00 PM12/17/25 at 9:00 AM and 5:00 PM12/18/25 at 9:00 AM and 5:00 PM12/23/25 at 9:00 AM and 5:00 PM12/25/25 at 9:00 AM and 5:00 PM12/26/25 at 9:00 AM12/27/25 at 9:00 AM and 5:00 PM12/28/25 at 9:00 AM and 5:00 PM12/29/25 at 9:00 AM and 5:00 PM12/30/25 at 9:00 AM and 5:00 PM On 12/31/25 at 11:00 AM, S #1 observed Resident's #1 door closed, attempted to interview but unavailable. A staff was inside the room with the resident. On 12/31/25 at 11:04 AM, S #1 interviewed Registered Nurse #1 (RN #1) and reviewed the December 2025 eMAR for Midodrine administration outside the parameters. RN #1 confirmed she signed as given, and she stated, I did not give it to (resident), it was incorrect, I wonder why I signed it. RN #1 confirmed if SBP was over 120 mm/hg that she would not administer it. S #1 asked if she documented anywhere that it was not administered, and RN #1 replied she did not know. S #1 asked what the X indicated on the eMAR and RN #1 replied, X means it was not given. S #1 asked RN #1 how she was able determine what the B/P was if it was documented as X instead of an actual B/P, and there was no reply from RN #1. On 12/31/25 at11:24 AM, S #1 interviewed the second floor Charge Nurse (CN). S #1 also reviewed the eMAR with the CN specifically the Midodrine administration for December and she confirmed, Yes, those dates with SBP above 120 mm/hg should have been withheld. S #1 asked regarding the X on the eMAR, and the CN stated that vital signs were taken every shift. The CN confirmed that the B/P should had been documented instead of an X on the eMAR because the B/P should had been taken right before administering the Midodrine. On 1/5/26 at 11:27 AM, S #1 notified the License Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant DON (ADON), and Nurse Consultant (NC) regarding the concerns with Midodrine administration outside of the parameters and not following the PO. On 1/5/26 at 1:19 PM, the LNHA informed the surveyors that there were no additional information to be provided. A review of the facility' Administering Medications Policy dated 5/2025, revealed under Policy Interpretation and Implementation . #4. Medications (meds) are administered in accordance with prescriber orders, including any required time frame . #8. If a dosage is believed to be inappropriate .the person preparing or administering the med will contact the prescriber, the resident's attending physician to discuss the concerns . 2. On the12/30/25 at 9:06 AM, Surveyor #2 (S #2) observed Registered Nurse #2 (RN #2) prepare to administer meds to Resident #83. S #2 observed the following active PO on the resident's eMAR, the screen containing the order was shaded in red: (continued on next page)

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	315526	A. Building B. Wing	01/05/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Insulin Aspart Subcutaneous (SQ) Solution Pen-injector 100 unit/ml (unit/milliliters) inject as per sliding scale: if 0 - 149 = 0 unit SQ;150 - 200 = 2 units SQ;201 - 250 = 4 units SQ;251 - 300 = 6 units SQ;301 - 350 = 8 units SQ;351 - 400 = 10 units SQCall MD (Medical Doctor) for BS (blood sugar) result 350 or more, SQ four times a day for DM (diabetes mellitus). Ordered to be given at 7:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM. S #2 asked RN #2 if the insulin aspart was ordered for 7:30 AM, and why was it being given now, and RN #2 stated, we like to wait till the resident eats to give insulin. S #2 asked RN #2 when the resident's fasting (pre-meal) BS reading was taken, and RN #2 stated it was taken around 7:30 AM. S #2 asked RN #2 if the resident's BS would have changed at all between 7:30 AM and now, especially since they ate, and RN #2 stated, possibly. S #2 observed on the medication cart (med-cart) a notebook with blood sugar results recorded on them. RN #2 verified that was where she got the results from. S #2 observed RN #2 prepare 2 units of insulin aspart based on the BS of 159 from 7:30 AM. S #2 observed RN #2 administered the insulin aspart to the resident at 9:33 AM. S #2 reviewed the EMR for resident #83, and revealed: A review of the Order Summary Report (OSR) reflected a PO for the following: Insulin aspart SQ Solution Pen-injector 100 unit/ml inject as per sliding scale: if 0 - 149 = 0 unit SQ; 150 - 200 = 2 units SQ; 201 - 250 = 4 units SQ; 251 - 300 = 6 units SQ; 301 -350 = 8 units SQ; 351 - 400 = 10 units SQ Call MD for BS result 350 or more, SQ four times a day for DM. The EMR also revealed an eMAR, which reflected the same order for insulin aspart, with a scheduled time of 7:30 AM, amount administered of 2, and an entry for BS of 159. The eMAR also revealed a location of administration report, which reflected for insulin aspart on 12/30/25, scheduled time 7:30 AM, administered time at 9:44 AM. On 12/31/25 at 12:00 PM, S #2 discussed concerns with the med-pass with the DON in the presence of the LNHA. S #2 asked if the nurses should always follow the physician's med orders for med accuracy and timing unless otherwise instructed by the physician, and the DON stated yes, they should always follow the med orders. S #2 asked if it would be appropriate to administer a med such as insulin, with a specific time before a meal, two hours later and after the meal, and the DON stated no, it should be given as ordered. S #2 asked if nurses should use a BS reading that was two hours old to calculate a dose of insulin, and the DON stated no, the BS reading should be current. .On 1/5/26 at 9:11 AM, S #2 interviewed the facility Consultant Pharmacist (CP) by phone. The surveyor asked the CP if the staff should administer meds per PO, and the CP stated yes, the staff should always follow the PO. S #2 asked the CP if the staff should use a BS reading that was two hours old to determine a dose of insulin, and the CP stated no, the BS reading should be current and timely. On 1/5/26 at 10:55 AM, S #2 met with the LNHA, DON, ADON, and NC for any further responses. The LNHA stated that RN #2 was observed on med-pass was suspended and would require further education. The NC stated that the residents' physicians were called and informed of the errors. A review of the facility's Administering Medications Policy, dated updated 5/2025, reflected under 4. (continued on next page)

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	315526	A. Building B. Wing	01/05/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Meds are administered in accordance with prescriber orders, including any required time frame . 7. Meds are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The LNHA provided no further pertinent information. N.J.A.C 8:39-11.2 (b); 29.2(d)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure a.) medication was removed from active inventory when resident was discharged from the facility for 1 of 4 medication carts inspected and b.) emergency cart (ecart) supplies were not expired for 1 of 1 ecart inspected.The deficient practices were evidenced by the following:1.On [DATE] at 10:55 AM, the surveyor inspected the second floor medication cart #2 (medcart #2), in the presence of the Licensed Practical Nurse (LPN), and both observed Unsampled Resident #1's (UR #1's) Cosopt Ophthalmic Solution 2-0.5 % bottle was inside medcart #2. The surveyor asked the LPN if the resident was still at the facility, and he responded no, the resident was discharged (d/c'd) to home probably two days ago. The LPN confirmed that the medication (med) should have been disposed of once resident was d/c'd to home. He also stated that he would dispose it, and he removed it from the medcart. 2. On [DATE] at 11:14 AM, the surveyor inspected the third floor ecart in the presence of the LPN/UM (Unit Manager), and both observed the following expired supplies:-two suction catheter kits with an expiration date (ED) of [DATE]-two suction tubing with an ED of [DATE]-two suction tubing with an ED of [DATE]-one suction tubing with an ED of [DATE]-one non rebreather mask with an ED of [DATE]-one non rebreather mask with an ED of [DATE]-IV (intravenous) needles #22 with an ED of [DATE]-IV needles #24 ED of [DATE]. On that same date and time, the LPN/UM stated, I got the point, there should be no expired supplies inside the ecart, and they should not be used if they were expired. The surveyor observed the LPN/UM opened the first three drawers of the ecart from the top during inspection and did not further proceed to other drawers. The LPN/UM further stated that it was the 11-7 shift Supervisor's responsibility to check the ecart to ensure they were complete, and supplies were not expired. On [DATE] at 12:53 PM, the surveyor interviewed the Director of Nursing (DON) with regard to controlled med and ecart. The DON stated that it was the responsibility of the 11-7 shift Supervisor to check the ecart and the expired supplies should have been removed. At that same time, the surveyor notified the DON of the above concerns with medcart #2 for UR #1, and the ecart in the third floor. The DON confirmed that the d/c'd resident's medications (meds) should be removed from the medcart. The DON stated that there should be no expired supplies in the ecart. On [DATE] at 11:11 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, Nurse Consultant (NC), and Assistant Director of Nursing (ADON). The LNHA stated that the med was for a d/c'd resident and facility policy allowed certain frame up to 30 days. The LNHA further stated that the eye drop was not expired, and the resident was d/c'd 2-3 days prior. On [DATE] at 1:19 PM, the LNHA informed the survey team that there were no further information to provide, and the survey team could proceed with decision making. NJAC 8:39-29.4(e)(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315526	A. Building B. Wing	01/05/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to perform testing of close contacts to resident that tested positive for COVID-19 to prevent further spread for 2 of 3 identified COVID positive incidents. This deficient practice was evidenced by the following:Reference: A review of the Centers for Disease Control (CDC) Infection Control Guidance: SARS-CoV-2, dated June 24, 2024, reflected the following but was not limited to:This guidance applies to all U.S. (United States) settings where healthcare is delivered, including nursing homes and home health. The recommendations in this guidance continue to apply after the expiration of the federal COVID-19 Public Health Emergency.Under Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic.Perform SARS-CoV-2 Viral TestingAnyone with even mild symptoms of COVID-19,regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible.Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.Under Nursing HomesResponding to a newly identified SARS-CoV-2-infected HCP (Healthcare Personnel) or residentWhen performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority.A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed.The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status.Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. On 12/30/25 at 12:48 PM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP) regarding process for COVID-19 and outbreak response. The ADON/IP stated that there were two residents that tested positive for COVID-19. The ADON/IP stated that the residents were roommates and that when the first resident tested positive, the roommate was moved to another room but kept on isolation since they were considered a PUI (Person Under Investigation). The ADON/IP stated that a few days later the second person tested positive and they were placed back into the same room with the first resident. The ADON/IP stated I do clinical on floors and trying 30 hours. The ADON/IP stated that the Local Health Department (LHD) was emailed over the weekend to confirm if they were in an outbreak. The ADON/IP stated that on the unit and in the facility mask were optional but encouraged. She added that full personal protective equipment (PPE) was required with a N95 mask to enter the COVID-19 positive resident room. The surveyor asked the ADON/IP if the LHD had given any recommendations or guidance. The ADON/IPO stated that she did not know if they had given any recommendations this time. She added that if they did that they would follow it. At that same time, the ADON/IP stated that she did contact tracing for the initial resident that tested positive and that the Resident Representative (RR) was not feeling well but that the RR did not test for COVID-19. The ADON/IP stated that the second resident was asymptomatic and then two days later developed a slight cough, and we tested the resident and, they were positive. The surveyor asked if any of the staff were tested. The ADON/IP stated that the staff were not tested. She added that she was checking with the LHD to see if they required testing. A review of the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's provided email from LHD to the facility dated 12/29/25 at 1:23 PM, included the following but was not limited to: I received a message from [other LHD staff] that you have two covid cases that are in the same room. I just wanted to follow up to verify that this would be an outbreak. If there are two or more covid cases within onsets of covid within 7 days of each other and are linked then this would be an outbreak. Since they are in the same room it sounds as though this an outbreak as indicated in your survey.Below is the guidance from the NJ (New Jersey) Department of Health for testing close contacts of the covid cases.If COVID-19 is suspected, asymptomatic patients having close contact with an ill individual should have a series of three viral tests, with the first test no less than 24 hours after exposure. If negative, the second test should be taken 48 hours after the first, and if negative again, the third test should be taken 48 hours after the second.The full guidance was also provided. On 12/31/25 at 11:29 AM, the surveyor interviewed the ADON/IP who stated that she had to check if the LHD sent an email with any update. She added that there were no new positives. On 1/2/26 at 9:00 AM, the surveyor asked for the line listing for COVID-19 which now had a third resident that tested positive. The Licensed Nursing Home Administrator (LNHA) stated that they had not received any further emails from the LHD, that they only received the initial email. A review of the facility provided line listing and electronic medical record included the following: First COVID-19 resident (Resident #5) tested positive on 12/26/25. Second COVID-19 resident (Resident #178) tested positive on 12/28/25. Third COVID-19 resident (Resident #124) tested positive on 12/31/25. On 1/2/26 at 10:55 AM, the surveyor interviewed the second floor Charge Nurse (SFCN) regarding the process for when a resident tests positive for COVID-19. The SFCN stated that the resident was placed on strict isolation and contact tracing was done to see whoever had been exposed or taking care of the resident. She added that the Director of Nursing (DON) or Assistant Director of Nursing (ADON) did the contact tracing. The SFCN stated that if occurred on the weekend, the supervisor would notify on call person. The SFCN stated that staff were asked if they want to get tested and if they have any symptoms. The SFCN stated that she was not aware of what the contact tracing was for the three residents that were COVID-19 positive. The surveyor asked if any staff were tested. The SFCN stated not to my knowledge. On 1/2/26 at 11:20 AM, the ADON/IP stated that another resident had tested COVID-19 positive. The ADON/IP stated that contact tracing was done for the third resident. The ADON/IP stated that anyone found to be a close contact was tested which included one nurse and no one tested positive. The ADON/IP stated that originally after the first positive, no staff or residents were tested. The ADON/IP stated that on 12/31/25, two nurses were tested after the third COVID-19 positive resident. The ADON/IP stated that we ask staff to test once in outbreak and if there were no symptoms we do not really test. The surveyor showed the ADON/IP the email from the LHD that the facility provided and asked if the guidance on the email was done. The ADON/IP stated that they did not test any residents. The ADON/IP stated that they test people that were close to the resident if symptomatic or sick. The surveyor asked if they tested asymptomatic close contacts. The ADON/IP stated that she did not believe they did. The surveyor asked if the two nurses that were tested were symptomatic. The ADON/IP stated that she did not believe they were symptomatic. The ADON/IP stated that the Resident #124 had a cough on 12/22/25, and was tested on [DATE], but was negative at that time. On 1/2/26 at 11:56 AM, the ADON/IP provided the surveyor contact tracing that was done for Resident #5, #178 and #124. A review of the contact tracing included the following:Resident #5 had Contact tracing sheet which indicated the resident tested positive on 12/26/26. There was no documentation to indicate any staff or residents that were close contacts. There was no documentation that any staff or residents were tested. Resident #178 had Contact Tracing sheet which had under actions taken: the resident tested positive on 12/28/25. Moved resident to another room. Strict iso (isolation) started. No s/s (signs and symptoms) of covid. There was no documentation to indicate any staff or residents that were close contacts. There was no documentation that any staff or residents were tested. Resident #124 had Contact Tracing sheet which under actions taken had multiple orders. There was no documentation to indicate any staff or (continued on next page)

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	315526	A. Building B. Wing	01/05/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents that were close contacts. There was no documentation that any staff or residents were tested. There was an additional paper that was handwritten that had 13 staff members listed under Staff Encountered. There were also six staff members who were therapists for Resident #124 from 12/22/25 to present. Next to each therapist name was written asymptomatic. Additional documentation provided included three COVID-19 Antigen test result sheets. Two of the result sheets were for Nurse #1, which indicated that on 12/31/25 Nurse #1 refused and that on 1/2/25 was tested and the result was negative. The 3rd sheet was for Nurse #2, which indicated that on 12/31/25 was tested and the result was negative. There were no additional tests for Nurse #2. On 1/2/26 at 12:49 PM, the surveyor interviewed the Director of Nursing (DON) about the process for testing close contacts during an outbreak of COVID-19. The DON stated that if a resident tested positive and a CNA was in contact then if the CNA was symptomatic then we would test the CNA. The DON stated that masking was optional in the facility and that masking was only required if for entering an iso room that had a COVID-19 positive resident. The surveyor asked the DON if testing of close contacts were performed. The DON stated that he was not sure if testing was done. He added that he was not aware if testing was done and that he did not test anyone. The surveyor asked the DON if he received the emails from the LHD that had the guidance. The DON stated that he did not do anything with the LHD emails. He added that he would get informed if a resident came in the facility with Covid. On 1/2/26 at 12:55 PM, the surveyor asked the LNHA if she received the LHD emails. The LNHA confirmed she received the emails. The surveyor asked if anyone else was tested. The ADON/IP stated that the CNA was tested and that no one else was tested. The surveyor asked about the contact tracing that was provided to the surveyor that was on a handwritten paper listing the therapists that were in contact with the resident (the third resident that tested positive) and if they were tested. The ADON/IP confirmed that they were not tested. She stated that they were asymptomatic and that they had no signs that they were sick. The surveyor asked the ADON/IP if someone would test COVID-19 positive even if they were asymptomatic. The ADON/IP stated that they could test positive even if no symptoms. The ADON/IP stated that the therapists were not tested and that they wore masks. The ADON/IP stated that staff were not tested originally because they were waiting for guidance from the LHD and confirmation we were in an outbreak. The ADON/IP stated that they did not get the confirmation email from LHD with the outbreak # until 12/30/25, and that the first positive resident was on 12/26/25, and the second was on 12/28/25. At that time, the LNHA stated that during the contact tracing the staff told them they were wearing masks. The LNHA provided the surveyor an additional email the facility received from the LHD dated 12/30/25 at 10:48 AM, which included an outbreak number and the following recommended actions in response to new cases but not limited to: Conduct contact tracing on all resident and staff cases. Conduct testing of close contacts as appropriate (on days 1, 3, and 5). If the facility was unable to perform contact tracing, broad based testing of the unit/wing/facility can be conducted (every 3-7 days until no new cases are found for 14 days). Be sure to follow all applicable federal and state directives. On 1/2/26 at1:22 PM, the surveyor notified the LNHA, DON and ADON/IP the concerns that the facility did not test any close contacts of Resident #5 and #178 and did not test all close contacts of Resident #124 in order to prevent the spread of COVID-19. On 1/5/26 at 11:06 AM, in the presence of the LNHA, DON and Nurse Consultant (NC), the ADON/IP stated that they started COVID-19 testing on 12/31/25, after the third resident (Resident #124) tested positive. The ADON/IP stated that on 12/30/25 they were told by the LHD that they had an outbreak and that they were testing on day 1, 3 and 5. A review of the undated facility's Covid 19 Outbreak Policy and Recommended Actions in Response to New Cases Policy included the following:-Immediately isolate and place on COVID-19 transmission-based precautions.-Conduct contact tracing on all resident and staff cases.-Conduct testing of close contacts as appropriate (as directed by LHD)If the facility is unable to perform contact tracing, broad based testing of the unit/wing/facility can be conducted (every 3-7 days until no new cases are found for 14 days).-Be sure to follow all applicable federal, state, and Local health department directives. Under Outbreak (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Management2. Testing: Use a contact tracing or broad-based strategy to test and identify additional cases. A review of the facility's COVID-19 Testing Requirements Policy with a revised date of 9/2024, included the following:Testing of Staff with a Higher-Risk Exposure and Residents who have a Close ContactThis testing is used when a staff or resident has been exposed to COVID-19 but is asymptomatic.1. Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection.a. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.Testing of Staff and Residents During an Outbreak Investigation1. An outbreak investigation is initiated when two new case of COVID-19 occurs among residents or one staff member to determine if others have been exposed.3. A single new case of COVID-19 infection in any staff or resident should be evaluated to determine if others in the facility could have been exposed. 4. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e/d., unit, floor.) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. a. if the facility is able to identify close contacts of the individual with COVID-19, focused testing may be conducted based on known close contacts. NJAC 8:39-19