

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Livia Health and Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1 South Ridgedale Avenue East Hanover, NJ 07936	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48617</p> <p>Complaint #: NJ00183458</p> <p>Based on observations, interviews, and review of pertinent facility documents on 02/25/2025 and 02/26/2025, it was determined that the facility failed to ensure that a resident (Resident #1) was free from neglect when it failed to provide the required care and services to meet the need of the Resident and follow its policies titled Abuse Prevention Program, Elopements and Wandering Residents, and Tracker for Residents Leaving the Building. On 02/10/2025, Resident #1 was picked up from Dialysis by the facility's van driver and was never brought back inside the building after the driver parked the vehicle in the parking lot at 5:00 pm and left Resident #1 sitting inside in her/his wheelchair unattended for 5 hours. The nursing staff knew Resident #1 should return from Dialysis at 5:00 pm but did not inquire about the Resident's whereabouts.</p> <p>The Licensed Practical Nurse (LPN #1) who was assigned to Resident #1 was notified multiple times by the Certified Nursing Assistants (CNAs) that Resident #1 did not return to the facility from her/his appointment, but LPN #1 did not follow up with the CNAs concerns. LPN #1 failed to notify the nursing supervisor (NS) of Resident #1 not returning from her/his dialysis appointment until 9:48 pm (4 hours and 48 minutes) after the Resident's expected return time. This resulted in Resident #1 missing her/his scheduled mealtime, medications, and treatment services for the shift. After the NS was notified, a search was initiated, and Resident #1 was found at 10:27 pm by the NS. Resident #1 was lying on the van floor with the Resident's wheelchair behind her/him. Resident #1 was assessed by the NS and stated, I am cold. When Resident #1 was found, her/his temperature was obtained by staff, and the temporal [forehead] reading of the Resident's temperature was 92.0 degrees Fahrenheit. Resident #1 was then transferred to an acute care hospital emergency room (ER) for hypothermia [low body temperature] due to exposure to the cold for five hours.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>This deficient practice created an Immediate Jeopardy (IJ) to the health and well-being of Resident #1 and placed all other residents who had an appointment and were transported by the facility's van and staff in an IJ situation, placing the residents at risk of being left in the van in the facility's parking lot after she/he was picked up from her/her appointment by the staff. The IJ was determined to have existed on 02/10/2025 at the time of the incident through 02/13/2025 when the facility corrected the noncompliance. The facility provided documented evidence of a Plan of Correction (POC) that was initiated at the time of the incident on 02/10/2025 and completed before the beginning of the survey on 02/25/2025 to the Surveyor, which included education and training to all nursing and non-nursing staff on elopement/missing person, safety measures (including the check-mate system and transport checklist), revised policies on transportation and tracker logs, rounding, shift to shift report and documentation.</p> <p>This deficient practice was identified for 1 of 3 residents (Resident #1) who had appointments that required facility transportation and was evidenced by the following:</p> <p>A review of the Facility Reportable Event (FRE), a document submitted by the facilities to report incidents to the New Jersey Department of Health (NJDOH), with date of event of 02/10/25, included a timeline as follows:</p> <ul style="list-style-type: none"> - 1009 [10:09 am] Transfer log indicates [the] time Resident #1 [name] left the facility. - 1530 [3:30 pm], Resident [unsampled Resident #1] is transported back to [the] facility (front entrance). - 1613 [4:13 pm], Resident [unsampled Resident #2] is transported back to [the] facility (front entrance). - 1624 [4:24 pm], transporter [name] leaves the facility. - 1700 [5:00 pm], transporter [name] drives the van into [the] parking spot. - 1702 [5:02 pm], transporter [name] exits the van and walks to the rear of the building. - 2148 [9:48 pm], the nurse assigned [name], Licensed Practical Nurse (LPN) #1, reached out to the nursing supervisor to inquire about the Resident's return. - 2149 [9:49 pm], [the] nursing supervisor called the dialysis center x 3 [three times] and the main center x 3, but there was no answer. A building search was initiated, and the transfer log was checked. - 2202 [10:02 pm], the nursing supervisor called the Resident's [family member]. [The] building search continued. - 2204 [10:04 pm], the nursing supervisor called the van driver [name] to confirm the Resident [name] returned to [the] facility. Search continued. - 2221[10:21 pm], the nursing supervisor exited the front of the building to check the van. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- 2222 [10:22 pm], the nursing supervisor checks both sides of the van.</p> <p>- 2223 [10:23 pm], the nursing supervisor returns to the building to locate the key for the van.</p> <p>- 2227 [10:27 pm], the nursing supervisor exits the rear of the building, returns to [the] van[,] and opens it. Resident [name] was observed lying on the floor with a wheelchair positioned behind her/him. The nursing supervisor runs back to the building to request additional assistance.</p> <p>- 2231 [10:31 pm], the nursing supervisor starts the van (to warm it).</p> <p>- 2232 [10:32 pm], additional staff members arrived at the van to help.</p> <p>- 2234 [10:34 pm], the back door of the van opened. The Resident [name] was transferred to the wheelchair.</p> <p>- 2235 [10:35 pm], staff providing blankets.</p> <p>- 2237 [10:37 pm], Resident arrived back in [the] building, transferred to [the] bed, and assessed; warm packs and blankets [were] provided.</p> <p>- 2243 [10:43 pm], the Ambulance was called.</p> <p>- 2300 [11:00 pm] (Approximately) [the Resident was] transferred to the [Acute Care Hospital] [name] via Ambulance [name] with 2 [emergency medical technicians] EMTs.</p> <p>- 2331 [11:31 pm], The Resident's niece [name] [was] provided an update.</p> <p>The Plan of Correction (POC) included the following:</p> <p>- On 02/10/2025, after the incident, the family and MD (Doctor) were notified; the driver and the nurse were suspended pending investigation and subsequently were terminated. The transport van was taken out of service until safety measures can be put in place.</p> <p>- Safety measures:</p> <p>a) Purchase of a safety device system (child check-mate system). The Child Check-Mate System is a safety system that reminds drivers to check for children/residents after each route. The alarm system acts as an electronic reminder to drivers.</p> <p>b) Use of Resident Transport Safety Checklist (for all facility van drivers)- Before departing, upon arrival at the destination, and upon returning to the community, Resident tracking sign-off (a second staff member to sign tracker when Resident confirms that all transported residents have returned safely, Accountability and 2 Signatures. This checklist must be followed for every trip to ensure resident safety.</p> <p>- On 02/10/2025 to 02/13/2025: In-services and Education provided to all staff on the following:</p> <p>02/10/2025 - Topic: Elopement/Missing Person.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>According to the Admission Record (AR), Resident #1 was admitted to the facility with the following diagnoses, including but not limited to ESRD [End-Stage Renal Disease], nonrheumatic aortic (valve) stenosis [heart problem], hyperkalemia [condition wherein there is a high level of electrolyte potassium in the blood], muscle weakness (generalized), abnormalities in gait and posture, and cerebral ischemia.</p> <p>According to the Minimum Data Set (MDS), an assessment tool that comprehensively assesses a resident's functional capabilities, dated 02/08/2025, Resident #1's Brief Interview for Mental Status (BIMS) Summary Score was 10, revealing moderately impaired cognition. The MDS further revealed in Section GG-Functional Abilities that Resident #1 required supervision or touching assistance to maximal assistance in her/his completion of Activities of Daily Living (ADLs).</p> <p>A review of Resident #1's Care Plan (CP), a document that reflects and addresses a resident's health focus or problem need area with applicable and appropriate interventions, showed a CP Focus [problem/need area]: [Resident's name] needs hemodialysis r/t (related to) renal failure Mon-Wed-Fri [Monday-Wednesday-Friday] at [name of dialysis center] pick up time 10:30 am [morning] chair time [dialysis session starts] 11:15 am. The CP further revealed Resident #1 had a CP Focus of the following:</p> <p>-CP Focus: [Resident's name] has an ADL self-care performance deficit r/t (related to) decrease[d] mobility. Under Focus included but was not limited to the following: [Resident's name] has a pacemaker r/t Atrial Fibrillation (episodes of irregular heart rhythm). [Resident's name] has congestive heart failure (commonly known as heart failure, a chronic condition in which the heart does not pump blood as well as it should). [Resident's name] is at risk for falls r/t deconditioning and gait/balance problems - actual fall 12/30. [Resident's name] is at risk for malnutrition d/t (due to) ESRD (End-Stage Renal Disease) on HD (hemodialysis), T2DM (Type 2 Diabetes Mellitus), CHF (Congestive Heart Failure), Dysphagia (difficulty swallowing), h/o (history of) skin breakdown, variable PO [by mouth] intake - Provide diet as ordered Renal, Cardiac diet, Regular texture, Thin liquids. At risk for pain related to a decrease in mobility and recent hospitalization .</p> <p>A review of Resident #1's Order Summary Report (OSR), a document that reflects the physician orders (POs) with active orders as of 02/10/2025, showed that the Resident had the following POs:</p> <p>-Resident had ordered diet: Renal diet, Regular texture, thin consistency, Cardiac with an order date of 11/07/2024.</p> <p>-Resident receives Dialysis at [name and address of center]. Approximate pickup time: 10:30 am [morning] Approximate chair time: 11:15 am Schedule: Mon [Monday], Wed [Wednesday], Fri [Friday] with an order date of 11/07/2024.</p> <p>-Evaluate dialysis access site for bleeding and signs and symptoms of infection; if present, notify PMD [the primary Doctor] every shift with an order date of 11/07/2024.</p> <p>-Vital Signs post hemodialysis in the evening every Monday, Wednesday, and Friday with an order date of 11/07/2024.</p> <p>-Amiodarone HCL [hydrochloride] Tablet 200 MG [milligram]. Give 1 tablet by mouth one time a day for abnormal heart rhythm. Hold for HR [heart rate] less than [below] 60 with an order date of 11/07/2024.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Dulcolax Suppository [medication given by rectum] 10 MG (Bisacodyl) [common name] insert 1 suppository rectally every 24 hours as needed for constipation with an order date of 11/07/2024.</p> <p>-Metoprolol Succinate ER [medication for high blood pressure] Tablet Extended Release 24 hour 25 MG. Give 0.5 tablet by mouth one time a day for AFIB [atrial fibrillation, irregular heart rhythm]. Give with or immediately after a meal. Hold for SBP [systolic blood pressure, the upper number in a blood pressure reading which represents the pressure of blood in a person's arteries when their heart beats], less than 100 or HR [heart rate] less than 60 (0.5tab=12.5mg) with an order date of 11/07/2024.</p> <p>-Pantoprazole Sodium [medication that reduces the amount of acid in the stomach] Tablet Delayed-Release 40 MG Give 1 tablet by mouth one time a day for GERD [gastroesophageal reflux disease]. Swallow whole with an order date of 11/07/2024.</p> <p>-Senna Tablet [medication for constipation]8.6 MG (Sennosides)[common name] Give 2 tablets by mouth at bedtime for constipation. Take plenty of water with an order date of 11/07/2024.</p> <p>-Sevelamer HCL Tablet 800 mg [milligram]. Give one tablet by mouth two times a day every Monday, Wednesday, and Friday for hypocalcemia (low blood calcium level). Give with meals. Swallow whole. Do not crush or chew. Dialysis days with an order date of 11/07/2024.</p> <p>-Sevelamer HCL Tablet 800 mg [milligram]. Give one tablet by mouth with meals every Tuesday, Thursday, Saturday, and Sunday for hypocalcemia (low blood calcium level). Give with meals. Swallow whole. Do not crush or chew. Nondialysis days with an order date of 11/07/2024.</p> <p>A review of Resident #1's electronic Medication Administration Record (eMAR) dated 2/1/2025-2/28/2025 indicated the Resident was scheduled for the following. The medications and drink supplement were not administered:</p> <p>-Glucerna (nutrient drink supplement) one time a day for being at risk for malnutrition 8oz [ounce] po [by mouth] at 1800 [6:00 pm].</p> <p>-Senna Tablet: Two tablets are taken at bedtime with plenty of water at 2100 [9:00 pm].</p> <p>-Sevelamer HCL Tablet 800 mg [milligram]. Give one tablet by mouth two times a day every Mon, Wed, and Fri for hypocalcemia (low blood calcium level). Give with meals. Swallow whole. Do not crush or chew. Dialysis days at 0830 [8:30 am] and 1730 [5:30 pm].</p> <p>-Vital signs monitoring every day and evening shift</p> <p>-Barrier cream to sacrum every shift.</p> <p>A review of Resident #1's Progress Notes (PN) with an effective date of 02/10/2025 22:27 [10:27 pm] and documented by the Director of Nursing (DON) revealed, Notified by nursing supervisor . [Resident #1] [was] observed lying on the floor in the transport van. [The] Resident states, I am cold. Assistance from additional staff is requested. Staff arrived to assist with the transfer to [the] wheelchair and bed. Upon arriving in bed, the Resident was assessed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The PN further revealed that Resident #1 had an Initial temp 92.0 (temporal). Skin assessment revealed no new findings. Blankets and warm packs [were] provided. [The] Resident was transferred to [name of hospital] ER for evaluation. [Doctor's name] and [Resident's family member's name] [were] notified. VS [vital signs]: 165/58 [blood pressure], HR [heart rate] 58, R [respiration]18, T [temperature] 97.2, O2 [oxygen] saturation 98% at room air. Resident transferred via stretcher, accompanied by 2 EMTs</p> <p>A review of the facility's Summary of Investigation (SOI) under Description: On Monday, 2/10/25 at approximately 2227 [10:27 pm], [Resident #1's name] was observed lying on the floor in the transport van. She/he was picked up by [van driver's name] from [dialysis center name] and was transported back to [facility's name] parking lot at 1700 [5:00 pm]. The SOI provided the following timeline:</p> <ul style="list-style-type: none"> - 1009 [10:09 am] Transfer log indicates [the] time Resident #1 [name] left the facility. - 2148 [9:48 pm], the nurse assigned [name], Licensed Practical Nurse (LPN) #1, reached out to the nursing supervisor to inquire about the Resident's return. - 2149 [9:49 pm], [the] nursing supervisor called the dialysis center x 3 [three times] and the main center x 3, but there was no answer. A building search was initiated, and the transfer log was checked. - 2202 [10:02 pm], the nursing supervisor called the Resident's [family member]. [The] building search continued. - 2204 [10:04 pm], the nursing supervisor called the van driver [name] to confirm the Resident [name] returned to [the] facility. Search continued. - 2221[10:21 pm], the nursing supervisor exited the front of the building to check the van. - 2222 [10:22 pm], the nursing supervisor checks both sides of the van. - 2223 [10:23 pm], the nursing supervisor returns to the building to locate the key for the van. - 2227 [10:27 pm], the nursing supervisor exits the rear of the building, returns to the van, and opens it. Resident [name] was observed lying on the floor with a wheelchair positioned behind her/him. The nursing supervisor runs back to the building to request additional assistance. - 2231 [10:31 pm], the nursing supervisor starts the van (to warm it). - 2232 [10:32 pm], additional staff members arrived at the van to help. - 2234 [10:34 pm], the back door of the van opened. The Resident [name] was transferred to a wheelchair. - 2235 [10:35 pm], staff providing blankets. - 2237 [10:37 pm], Resident arrived back in [the] building, transferred to [the] bed, and assessed; warm packs and blankets [were] provided. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- 2243 [10:43 pm], the Ambulance was called.</p> <p>- 2300 [11:00 pm] (Approximately) [the Resident was] transferred to the [Acute Care Hospital] [name] via Ambulance [name] with 2 [emergency medical technicians] EMTs.</p> <p>- 2331 [11:31 pm], The Resident's niece [name] [was] provided an update.</p> <p>On 02/25/2025, the Surveyor reviewed the statements obtained from staff during the investigation, which included the following:</p> <p>According to CNA #2's statement, on 02/10/2025 at around 3 pm [3:00 pm], she did her rounds and knew that Resident #1 went to Dialysis. At around 6 pm [6:00 pm], CNA #2 wrote, I went back [she/ he] [Resident #1] still not back [.] I notified the nurse, and I said to check with the Supervisor. I started putting the residents in bed. I checked a few times, [and] [she/he] was not back, it was about 8:40 pm [.] The CNA statement further revealed that the CNA asked LPN #1 if he/she had told the Supervisor that Resident #1 had not returned from Dialysis, and the nurse replied that he/she knew.</p> <p>According to CNA #3's statement, the CNA wrote: On February 10, I worked on [the] 3rd floor [on the] south wing, but I wasn't assigned to the patient [Resident #1]. I brought [Resident #1's] tray to the [room] because she was out to Dialysis. I told the nurse that the patient was still out and asked if he could call the place to find out what was going on. He [nurse] said, Ok[.]. Later on, we were picking up the trays, and the aide who was assigned to [Resident #1] told the [the nurse] to tell the Supervisor that [Resident #1] is [was] not back. The statement further revealed that the nurse had responded that he knew. Later, the nurse called the Supervisor to report that Resident #1 was not yet back from Dialysis.</p> <p>On 02/25/2025 at 1:35 pm, the Surveyor interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). The DON stated that LPN #1 notified the nursing supervisor about Resident #1 at around 9:48 pm, as was noted in his statement. The DON explained that the expectation was for the assigned nurse [LPN #1] to follow up on his residents, especially after hemodialysis or medical appointments. The DON stated LPN #1 was suspended and eventually terminated.</p> <p>On 02/26/2025 at 12:47 pm, the Surveyor interviewed the van driver via phone. The van driver stated that, at around 4:30 pm, he had picked up the Resident from the dialysis center. The van driver further stated, She/he [Resident #1] was in her/his wheelchair, put her/him in the vestibule, put on her/his seatbelt, and she/he was fine and did not complain of any pain or discomfort. At 5:00 pm, we arrived at the facility parking lot; I parked the van where I normally parked. I exited the van and walked to the rear of the building. In my mind, I wanted to go back to the building to finish some work. When the Supervisor called me that night, it was shocking to me. I was emotional. I drove her/him [the Resident] on several occasions[,] and I think I was not focused at that time.</p> <p>On 02/26/2025 at 1:27 pm, the Surveyor placed a call to LPN #1 for an interview, but the LPN did not return the call.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy titled: Policy: Abuse Prevention Program, with date revised on 5/21/2024, showed the following statement, This facility prohibits abuse, neglect, involuntary seclusion .from residents and will utilize the abuse prevention program to effectively prevent occurrences .screen and train staff, investigate, report, and respond to any occurrences. Furthermore, the facility's policy showed under paragraph Passive Forms of Resident Abuse . 2. Neglect - The failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect of goods or services may occur when staff are aware of residents' care needs, based on assessment and care planning, but are unable to meet the identified needs due to lack of training to perform intervention, lack of supplies, or lack of knowledge of needs of the Resident.</p> <p>A review of the facility's policy titled: Policy: Elopements and Wandering Residents with review date: 5/15/24, under Policy Explanation and Compliance Guidelines: .5. Procedure for locating missing Resident: a.Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol (code grey). b.The designated facility staff will look for the Resident .</p> <p>A review of the facility's policy titled: Policy: Tracker for Residents Leaving the Building, last revised 2/13/25, Under Procedure: 1. Receptionist will record Resident name, date, room number, name of person/transport company, destination, and time that Resident leaves the building; 2. Receptionist will then send out an email to the [facility name] team informing staff that Resident has left the building; 3. When the Resident returns from the appointment, the receptionist will record the return time on the tracking log. The receptionist will also ask the driver to sign the tracking log to confirm that they brought the Resident back into the building; 4. Receptionist will then send out an email to the LIVIA team informing staff that Resident has returned; 5. If the Resident does not return to the building within the expected duration, the receptionist will alert the nursing supervisor that the Resident has not yet returned; 6. If the Resident does not return to the building prior to reception change of shift, the receptionist will report to oncoming receptionist for continued follow up.</p> <p>N.J.A.C. 8:39-4.1(a)5</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Livia Health and Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1 South Ridgedale Avenue East Hanover, NJ 07936	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51144</p> <p>Complaint #: NJ00182762</p> <p>Based on observations, interviews, medical record review, and review of other pertinent facility documentation on 02/25/2025 and 02/26/2025, it was determined that the facility failed to develop comprehensive person-centered care plans (CP) for a resident (Resident #4) who wore incontinence underwear while in the facility, and failed to include a complete focus area for a resident (Resident #6) with breathing difficulty. The facility also failed to follow its policy titled Care Plans, Comprehensive Person-Centered.</p> <p>This deficient practice was identified for 2 of 2 residents and was evidenced by the following:</p> <p>During a incontinence tour on 02/25/2025 at 10:35 A.M. accompanied by the facility's Assistant Director of Nursing (ADON), the surveyor observed Resident #4 awake and dressed, sitting in a wheel chair in their room. The resident stood to show the surveyor and the ADON that they were wearing wearing incontinence underwear that was clean, dry and odor free. At 1:30 P.M., the Surveyor interviewed Resident #4, who stated that they were wearing a diaper while in the facility and that they had not used incontinence products at home. Resident #4 stated that they wore the incontinence brief while in the facility because they were unable to get assistance to the bathroom in time to avoid accidents. During a follow-up interview on 02/26/2025 at 12:37 PM Resident #4 stated that no staff member had explained the need for using the incontinence underwear to them. Resident #4 stated that they wore a brief in the hospital and the facility staff continued to use them when the resident arrived at the facility. The resident further stated that they didn't feel great about wearing incontinence briefs and it would be their preference to wear their own underwear.</p> <p>1. According to the Admission Record (AR), Resident #4 was admitted to the facility with diagnoses which included but were not limited to: encounter for other orthopedic aftercare; pathological fracture, right femur, subsequent encounter for fracture with routine healing; muscle weakness; and unspecified abnormalities of gait and mobility.</p> <p>A review of Resident #4's Admission/Readmission, assessment with an effective date of 02/07/2025 at 3:05 P.M., revealed under Bowel/Bladder that Resident #4 was continent of bladder and continent of stool. The document further revealed that Resident #4 did not wear incontinence products.</p> <p>According to the Minimum Data Set (MDS) an assessment tool dated 02/13/2025, Resident #4 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating that the resident's cognition was intact. The MDS also identified that the Resident #4 was occasionally incontinent of bowel and bladder and required partial or moderate staff assistance to move from sitting to standing and to walk ten feet.</p> <p>A review of Resident #4's CP initiated 02/07/2025 revealed no Focus, Goals, or Approaches related to Resident #4's bowel and bladder function or the use of incontinence products.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/25/2025 at 1:40 P.M., Certified Nursing Assistant (CNA) #1 stated that Resident #4 was continent and received assistance to the toilet. CNA #1 stated that Resident #4 expressed that they wanted to wear the incontinence brief in case they had an accident.</p> <p>2. According to the AR, Resident #6 was admitted to the facility with diagnoses that included but were not limited to: diverticulitis of large intestine without perforation or abscess without bleeding; gastrointestinal hemorrhage, unspecified; unsteadiness on feet; weakness; need for assistance with personal care; other reduced mobility; dementia in other diseases classified elsewhere, unspecified severity, without other behavioral disturbance; and Alzheimer's Disease with late onset.</p> <p>A review of Resident #6's MDS dated [DATE] revealed a BIMS score of 3 out of 15, which indicated that the resident's cognition was severely impaired.</p> <p>A review of Resident #6's CP initiated on 10/01/2024 included under Focus, The resident has altered respiratory status/difficulty breathing r/t [related to]. This section of the CP did not specify what Resident #6's altered respiratory status was related to.</p> <p>During an interview on 02/26/2025 at 12:12 PM, the Unit Manager (UM) stated that when admissions came into the facility a CP was generated automatically. The UM stated that UMs were responsible to personalize CPs with goals and interventions. The UM further stated that residents should have input in their CPs and should be informed of what is in the CP so that they knew what care to expect. The UM stated that residents who wore incontinence briefs should have a CP focus related to incontinence.</p> <p>During an interview on 02/26/2025 at 3:20 PM, the Assistant Director of Nursing (ADON) stated that UMs were responsible for updating CPs and including resident preferences. The ADON stated that it was important that CPs were kept up to date so that everyone knew how to care for the resident.</p> <p>During an interview on 02/26/2025 at 4:50 PM, the Director of Nursing (DON) stated that CPs were started when residents were admitted and should have been individualized to each resident. The DON stated that any member of the Interdisciplinary Team could have updated a CP and the best practice was to update CPs when new issues came up. The DON stated that the CP for Resident #4 should have included information about the resident's GI/GU (gastrointestinal/genitourinary) systems. The DON further stated that Resident #6's CP did not meet expectations because it was not customized with the resident's name and diagnosis.</p> <p>Review of the facility policy titled Care Plan Comprehensive Person-Centered, with an effective date of 04/01/2024, revealed under Policy Interpretation and Implementation, 7. The care planning process will: [.] c. Incorporate the resident's personal and cultural preferences in developing the goals for care. This section of the facility policy further revealed, 8. The comprehensive, person-centered care plan will: [.] g. incorporate identified problem areas;</p> <p>N.J.A.C. 8:39-11.2 (e)2</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51144</p> <p>Complaint #: NJ00182762</p> <p>Based on interviews, medical record review, and review of other pertinent facility documentation on 02/25/2025 and 02/26/2025, it was determined that the facility failed to a). obtain a Physician's Order (POs) after a wound consult recommendation for treatments b). follow a POs for treatment of a pressure ulcer, and c). follow its wound care policy for a resident with pressure ulcers to the sacrum. This deficient practice was identified for 1 of 2 residents (Resident #5) reviewed for pressure ulcers and was evidenced by the following:</p> <p>According to the Admission Record, Resident #5 was admitted to the facility with diagnoses which included but were not limited to Pneumonitis due to inhalation of food and vomit; coagulation deficit, unspecified; type 2 Diabetes Mellitus without complications; metabolic encephalopathy; and contusion of the right lower leg, subsequent encounter.</p> <p>Review of Resident #5's Admission/Readmission- V3 assessment dated [DATE] revealed that Resident #5 had bruising and swelling to both legs and scabs on their right and left knees. The Admission/Readmission-V3 assessment revealed that Resident #5 was assessed on the Braden Scale (a tool to measure the risk of pressure ulcer development) as at risk for pressure ulcer development. Further review of the document revealed that the resident had deep tissue injury (DTI) (area of discolored, intact skin due to damage of underlying soft tissue) to their sacrum.</p> <p>According to the Minimum Data Set (MDS), an assessment tool, dated 2/16/2025, Resident #5 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating that the resident's cognition was severely impaired. The MDS revealed that Resident #5 required staff assistance to roll left and right, move from sitting to laying, and move from laying to sitting. The MDS revealed that Resident #5 was always incontinent of urine and bowel. Further review of the Resident MDS revealed under Section M- Skin Conditions, no pressure ulcers or injuries listed under Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage.</p> <p>Review of Resident #5's care plan (CP) initiated 02/13/2025 and revised 02/20/2025 included the following: Under Focus: The resident has the potential for skin integrity r/t [related to] fragile skin. Rt. [right] lower leg hematoma, right lower leg distal shin, rt. proximal lower leg, left knee abrasion, sacrum pressure. Under Goal included: The resident will be free from skin tear[s] through the review date. Under Approaches included: If skin tears treat per facility protocol, Monitor/ document location size and treatment of skin tear. Report abnormalities, failure to heal, s/sx [signs/ symptoms of infection, maceration, etc. to MD [Medical Doctor]. Monitor for signs and symptoms of skin breakdown and report to MD as needed. Weekly treatment documentation will include measurement of each area of skin breakdown, including length, debt, type of tissue, exudate, and any other notable changes or observations.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a wound care consult progress note (PN) with an effective date of 02/14/2025 at 11:30 PM revealed that Resident #5 had a Sacral wound from pressure measuring 1.3 cm x 1.2 cm x 0.2 cm, the wound bed was covered 100% by yellow slough (soft, moist tissue that can appear during wound healing). There was moderate serous drainage. The recommendation for wound treatment was to Cleanse and pat dry, apply Santyl (a medication used to remove dead tissue from wounds) to the wound bed, cover with a foam dressing, and change daily. Apply zinc to surrounding areas twice daily.</p> <p>Reviewing the Order Summary Report (OSR), with a date range of 2/13/2025 through 2/28/2025, revealed Resident #5 had no POs for wound care treatment for the aforementioned recommendations from 02/13/2025 through 02/19/2025. On 02/20/2025, a new POs (to begin on 02/21/2025) was entered into the OSR for Collagenase (the generic name for Santyl) Ointment 250 units/ GM (per gram). Apply to sacrum topically every day shift and cover with a bordered foam dressing.</p> <p>On 02/25/2025 at 10:50 AM, Resident #5 was observed awake and talking, lying in bed with the head of the bed elevated. The ADON assisted the resident out of bed to the bathroom. The surveyor observed a bordered foam dressing intact to the resident's sacrum, which was dated 2/23, with the letters MP written on the dressing. During a second observation, on 02/26/2025 at 11:00 AM, wound care for Resident #5 was performed by the Licensed Practical Nurse (LPN #3) in the presence of the Unit Manager (UM). Resident #5 had the same bordered foam dressing intact to the sacrum dated 2/23 with the letters MP. The UM confirmed that the dressing was labeled with the date 2/23. The dressing was removed, and wound care was discarded as ordered by the physician by LPN #3, with a new dressing applied.</p> <p>A review of Resident #5's February 2025 Medication Administration Record (MAR) revealed initials in the boxes that indicated wound care was provided for Resident #5's sacral wound on 02/23/2025, 02/24/2025, and 02/25/2025. However, at the time of the observation, Resident #5's dressing was dated 2/23, indicating that the POs treatment was not carried out for the daily treatment and dressing changes since 2/23/25.</p> <p>During an interview on 02/26/2025 at 11:35 AM, Resident #5 stated that he/she thought there was a sore on their lower back but was unsure. The resident further stated that their dressing had not been changed on 02/25/2025. (BIMS of 3)</p> <p>The surveyor attempted to reach the nurses who initialed Resident #5's MAR indicating that they performed wound care to Resident #5's sacral wound on 02/24/2025 and 02/25/2025. There was no answer.</p> <p>During an interview on 02/26/2025 at 3:20 PM, the Assistant Director of Nursing (ADON) stated that the admitting nurse would conduct and document a skin assessment on admission. If wounds were present on admission, the practice was to follow hospital treatments until the wound care team evaluated the resident. The ADON further stated that it was the practice for the admitting nurse to reconcile medications and treatments with the physician. The ADON stated that it was expected that there would be a physician's order for all treatments, including wound care treatments. In addition, the ADON stated that the admitting nurse, UM, or Nursing Supervisor were responsible for obtaining admission orders, and POs were needed to ensure safe practice.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the same interview, the ADON stated that Resident #5's sacral wound and leg injuries were present when the resident was admitted . The ADON confirmed no orders for wound treatment for Resident #5 from 02/13/2025 to 02/20/2025. The ADON confirmed no documentation of wound treatment for Resident #5 from 02/13/2025 to 02/20/2025. The ADON stated that the only place where wound treatment would be documented was on the MARs or TARs. The ADON stated that Resident #5's dressing changes did not meet expectations of wound care because the date on the dressing would have indicated when it was changed.</p> <p>During an interview on 02/26/2025 at 3:20 PM, the Director of Nursing (DON) stated that skin assessment was part of the admissions process. The DON continued that it was the responsibility of the admitting nurse to obtain orders for wound treatments. The DON stated that she did not see orders for wound treatments from admission or the 02/14/2025 wound care recommendations. The DON stated that if there is no physician order, treatments cannot be documented in the TAR but could be documented in the progress notes. The DON further stated that the dressing observed on Resident #5 during wound care observation should not have been dated 2/23 if dressing changes were performed as ordered. The DON continued that the performance of dressing changes as ordered was important for wound healing and infection control.</p> <p>A review of the facility's Wound Care policy with a revised date of 6/19/24 revealed under the Preparation included Verify that there is a physician's order for this procedure. Further review of the same facility policy under Steps in the Procedure, 5. Put on exam glove[s]. Loosen tape and remove dressing. 6. Pull glove over dressing and discard into appropriate receptacle. Further review of the policy revealed 14. Dress wound. [.] [NAME] tape with initials, time, and date and apply dressing.</p> <p>NJAC 8:39-27.1(e)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48617</p> <p>Complaint #: NJ00183458</p> <p>Based on observations, interviews, and review of pertinent facility documents on 02/25/2025 and 02/26/2025, it was determined that the facility failed to ensure that a resident (Resident #1) was safe when it failed to follow its policies titled Elopements Wandering Residents, Resident Transportation, and Tracker for Residents Leaving the Building. On 02/10/2025, Resident #1 was picked up from Dialysis by the facility's van driver; the driver did not take Resident #1 into the building upon return to the facility; instead, the driver parked the vehicle in the parking lot at 1700 [5:00 pm], exited the vehicle and left the Resident in the van until she/he was found approximately 5 hours later. Resident #1 was found lying on the floor of the van with the wheelchair behind her/him by the Nursing Supervisor [NS]. When assessed, the Resident stated, I am cold. The initial temperature of the Resident obtained by staff showed a temporal [forehead] temperature of 92.0 degrees Fahrenheit. The Resident was then transferred to an acute care hospital emergency room (ER) for hypothermia [low body temperature] due to exposure too cold for five hours.</p> <p>This deficient practice created an Immediate Jeopardy (IJ) to the health and safety of Resident #1 and had the likelihood to impact all residents who went out for appointments and were transported by the facility vehicle and driver in an IJ situation of being left in the van in the facility's parking lot unattended after she/he was picked up from her/her appointment. The IJ was determined to have existed on 02/10/2025 at the time of the incident through 02/13/2025 when the facility corrected the noncompliance. There was sufficient evidence that the facility corrected the noncompliance and is substantially compliant at the time of the survey on 02/25/2025 for the specific regulatory requirements for F689. The Immediate Jeopardy Past Noncompliance started on 02/10/2025 and ended on 02/13/2025 when all nursing and non-nursing staff were educated and trained on elopement/missing person, safety measures (including the check-mate system and transport checklist), revised policies on transportation and tracker logs. This deficient practice was identified for 1 of 3 residents (Resident #1) who had Dialysis and/or appointments that required transportation by the facility.</p> <p>A review of the Facility Reportable Event (FRE), a document submitted by the facilities to report incidents to the New Jersey Department of Health (NJDOH), with date of event of 02/10/25, included a timeline as follows:</p> <ul style="list-style-type: none"> - 1009 [10:09 am] Transfer log indicates [the] time Resident #1 [name] left the facility. - 1530 [3:30 pm], resident [unsampled resident #1] is transported back to [the] facility (front entrance). - 1613 [4:13 pm], resident [unsampled resident #2] is transported back to [the] facility (front entrance). - 1624 [4:24 pm], transporter [name] leaves the facility - 1700 [5:00 pm], transporter [name] drives the van into [the] parking spot <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - 1702 [5:02 pm], transporter [name] exits the van and walks to the rear of the building. - 2148 [9:48 pm], the nurse assigned [name], Licensed Practical Nurse (LPN) #1, reached out to the nursing supervisor to inquire about the Resident's return. - 2149 [9:49 pm], [the] nursing supervisor called the dialysis center x 3 [three times] and the main center x 3, but there was no answer. A building search was initiated, and the transfer log was checked. - 2202 [10:02 pm], the nursing supervisor called the Resident's [family member]. [The] building search continued. - 2204 [10:04 pm], the nursing supervisor called the van driver [name] to confirm the Resident [name] returned to [the] facility. Search continued. - 2221[10:21 pm], the nursing supervisor exited the front of the building to check the van. - 2222 [10:22 pm], the nursing supervisor checks both sides of the van. - 2223 [10:23 pm], the nursing supervisor returns to the building to locate the key for the van. - 2227 [10:27 pm], the nursing supervisor exits the rear of the building, returns to the van, and opens it. Resident [name] was observed lying on the floor with a wheelchair positioned behind her/him. The nursing supervisor runs back to the building to request additional assistance. - 2231 [10:31 pm], the nursing supervisor starts the van (to warm it). - 2232 [10:32 pm], additional staff members arrived at the van to help. - 2234 [10:34 pm], the van's back door opened. The Resident [name] was transferred to the wheelchair. - 2235 [10:35 pm], staff providing blankets. - 2237 [10:37 pm], Resident arrived back in [the] building, transferred to [the] bed, and assessed; warm packs and blankets [were] provided. - 2243 [10:43 pm], the Ambulance was called. - 2300 [11:00 pm] (Approximately) [the Resident was] transferred to the [Acute Care Hospital] [name] via Ambulance [name] with 2 [emergency medical technicians] EMTs. - 2331 [11:31 pm], The Resident's niece [name] [was] provided an update. <p>The facility provided the Surveyor documented evidence of a Plan of Correction (POC) initiated at the time of the incident on 02/10/2025 and completed before the survey on 02/25/2025 of the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 02/10/2025, after the incident, the family and MD (Doctor) were notified; the driver and the nurse were suspended pending investigation and subsequently were terminated. [The] transport van was taken out of service until safety measures can be put in place.</p> <p>Safety measures:</p> <p>a) Purchase of a safety device system (child check-mate system). The Child Check-Mate System is a safety system that reminds drivers to check for children/residents after each route. The alarm system acts as an electronic reminder to drivers.</p> <p>b) Use of Resident Transport Safety Checklist (for all facility van drivers)- Before departing, upon arrival at [the] destination, upon returning to [the] community, Resident tracking signs off (a second staff member to sign tracker when Resident to confirm that all transported residents have returned safely, Accountability and 2 Signatures. This checklist must be followed for every trip to ensure resident safety.</p> <p>Education and in-services were provided to all staff as follows:</p> <p>02/10/2025 - Topic: Elopement/Missing Person.</p> <p>-On 02/11/2025 - Policy on Resident Transportation dated 04/07/2024 and revised/ updated on 02/11/2025.</p> <p>- On 02/11/2025 to 02/13/2025 - Policy on Tracker for Residents Leaving the Building dated 04/03/24 with a revised date of 02/11/2025 and 02/13/2025.</p> <p>- 02/13/2025 - Topics: Resident Transport Safety Checklist; Child Check- Mate in-service; Policy Revision for Tracker for Residents leaving the building.</p> <p>- On 02/13/2025 - [the] facility completed a Root-Cause-Analysis (RCA) Report [,] which included a conclusion and follow-up with [an] expected compliance date of 02/14/2025; final review date of 02/20/2025 and follow-up actions:</p> <p>a. conduct [a] post-implementation review in 3 months to ensure continued adherence.</p> <p>b. address[es] any ongoing issues with further policy adjustments if necessary.</p> <p>A review of Resident #1's Electronic Medical Record (EMR) revealed the following:</p> <p>According to the Admission Record (AR), Resident #1 was admitted to the facility with the following diagnoses, including but not limited to ESRD [End-Stage Renal Disease], nonrheumatic aortic (valve) stenosis [heart problem], hyperkalemia [condition wherein there is a high level of electrolyte potassium in the blood], muscle weakness (generalized), abnormalities in gait and posture, and cerebral ischemia.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Livia Health and Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 1 South Ridgedale Avenue East Hanover, NJ 07936	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>According to the Minimum Data Set (MDS), an assessment tool that comprehensively assesses a resident's functional capabilities, dated 02/08/2025, Resident #1's Brief Interview for Mental Status (BIMS) Summary Score was 10, revealing moderately impaired cognition. The MDS further revealed in Section GG-Functional Abilities that Resident #1 required supervision or touching assistance to maximal assistance in her/his completion of Activities of Daily Living (ADLs).</p> <p>A review of Resident #1's Care Plan (CP) showed a CP Focus [problem/need area]: [Resident's name] needs hemodialysis r/t (related to) renal failure Monday, Wednesday and Friday at [name of dialysis center] pickup time 10:30 am [morning] chair time [dialysis session starts] 11:15 am.</p> <p>A review of Resident #1's Progress Notes (PN) with an effective date of 02/10/2025 22:27 [10:27 pm] and documented by the Director of Nursing (DON) revealed, Notified by nursing supervisor .[Resident's name] [was] observed lying on the floor in the transport van. The PN further showed that the Resident stated, I am cold[.] Assistance from additional staff [were] requested. Staff arrived to assist with [the] Transfer to [the] wheelchair and bed. Upon arriving in bed, the Resident was assessed.</p> <p>The PN further revealed the Resident's initial temp 92.0 (temporal). Skin assessment revealed no new findings. Blankets and warm packs [were] provided. The Resident [was] transferred to [name of hospital] ER for evaluation. [Doctor's name] and [Resident's niece's name] [were] notified. VS [vital signs]: 165/58 [blood pressure], HR [heart rate] 58, R [respiration]18, T [temperature] 97.2, O2 [oxygen] saturation 98% at room air. Resident transferred via stretcher, accompanied by 2 EMTs .</p> <p>According to the facility's New Jersey Universal Transfer Form (NJUTF) dated 02/10/25 with Time of Transfer: 11 pm [11:00 PM] and Reasons for Transfer: Resident [came] back from (hemodialysis) H.D. Hypothermia (low body temperature) exposed to the cold x 5 hours [for 5 hours].</p> <p>A review of the facility's Summary of Investigation (SOI) under Description: On Monday, 2/10/25 at approximately 2227 [10:27 pm], [Resident #1's name] was observed lying on the floor in the transport van. She/he was picked up by [van driver's name] from [dialysis center name] and was transported back to [facility's name] parking lot at 1700 [5:00 pm]. The SOI provided the following timeline:</p> <ul style="list-style-type: none"> - 1009 [10:09 am] Transfer log indicates [the] time Resident #1 [name] left the facility. - 2148 [9:48 pm], the nurse assigned [name], Licensed Practical Nurse (LPN) #1, reached out to the nursing supervisor to inquire about the Resident's return. - 2149 [9:49 pm], [the] nursing supervisor called the dialysis center x 3 [three times] and the main center x 3, but there was no answer. A building search was initiated, and the transfer log was checked. - 2202 [10:02 pm], the nursing supervisor called the Resident's [family member]. [The] building search continued. - 2204 [10:04 pm], the nursing supervisor called the van driver [name] to confirm the Resident [name] returned to [the] facility. Search continued. - 2221[10:21 pm], the nursing supervisor exited the front of the building to check the van. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- 2222 [10:22 pm], the nursing supervisor checks both sides of the van.</p> <p>- 2223 [10:23 pm], the nursing supervisor returns to the building to locate the key for the van.</p> <p>- 2227 [10:27 pm], the nursing supervisor exits the rear of the building, returns to the van, and opens it. Resident [name] is observed lying on the floor with a wheelchair positioned behind her/him. The nursing supervisor runs back to the building to request additional assistance.</p> <p>- 2231 [10:31 pm], the nursing supervisor starts the van (to warm it).</p> <p>- 2232 [10:32 pm], additional staff members arrived at the van to help.</p> <p>- 2234 [10:34 pm], the van's back door opened. The Resident [name] was transferred to a wheelchair.</p> <p>- 2235 [10:35 pm], staff providing blankets.</p> <p>- 2237 [10:37 pm], Resident arrived back in [the] building, transferred to [the] bed, and assessed; warm packs and blankets [were] provided.</p> <p>- 2243 [10:43 pm], the Ambulance was called.</p> <p>- 2300 [11:00 pm] (Approximately) [the Resident was] transferred to the [Acute Care Hospital] [name] via Ambulance [name] with 2 [emergency medical technicians] EMTs.</p> <p>- 2331 [11:31 pm], The Resident's niece [name] [was] provided an update.</p> <p>The Surveyor reviewed the facility's video footage of the [location of the camera] parking lot, and real-time surveillance [with time stamped] showed the following:</p> <p>At 4:24 pm - the van was seen leaving the facility.</p> <p>At 4:59 pm - the facility van was seen coming back and into the driveway.</p> <p>At 5:00 pm - the driver drives [the] van on the left side area of the viewed parking lot.</p> <p>At 5:02 pm, the driver exited the van and walked towards the back of the building [towards the right side of the parking lot].</p> <p>At 5:03 pm - the driver appeared to wave at somebody in another van parked on the right side of the viewed parking lot.</p> <p>At 9:55 pm - the facility van was seen in the viewed parking lot.</p> <p>At 10:21 pm - the nursing supervisor was seen walking towards the van [coming from the left side of the viewed parking lot].</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>At 10:22 pm - the nursing supervisor reached the van, walked around the van with cell phone one in hand [Supervisor turned on light in her cell phone], and was seen walking back towards the left of the camera [building] while talking on her cell phone.</p> <p>At 10:26 pm - the nursing supervisor was seen walking back towards the van.</p> <p>At 10:27 pm - the nursing supervisor was seen opening the van and appeared to turn on the van's ignition.</p> <p>At 10:28 pm - the Supervisor was seen running back towards the building.</p> <p>At 10:30 pm - staff were seen running towards the van with the nursing supervisor behind them; they opened the back.</p> <p>At 10:36 pm - additional staff were seen running towards the van and noted carrying blankets.</p> <p>At 10:36:41 pm - the staff took Resident #1 in a wheelchair from the back of the van and towards the building. The Resident was noted with blankets on her/him.</p> <p>On 02/25/2025, the Surveyor reviewed the statements obtained from staff during the investigation.</p> <p>According to the receptionist's statement dated 2/11/2025, Around 10:00 pm, the [nursing supervisor] asked if I've seen [Resident #1] return from Dialysis. I checked my log, and her time in was blank, indicating she didn't return. Sometimes, I have to step away from the desk to either use the bathroom, let someone from Memory Care, or find a nurse . so I thought [driver's name] came and brought her to the room. I didn't see so I called him to confirm around 10:08 pm, and he said yes, he had brought her to her room, so I told [nursing supervisor], and she told me [Resident #1's name] was missing. We proceed to look through the building for her, and around 10:39 pm, [the nursing supervisor] finds her in the [facility name] transport bus.</p> <p>On 02/25/2025 at 1:35 pm, the Surveyor interviewed the Licensed Nursing Home Administrator (LNHA). The LNHA stated the van is owned by the facility and had been used until after the incident and would not use it until after safety measures were installed. LNHA further stated she reviewed the incident and video footage; immediate actions were taken to prevent recurrence, and the policy on transportation and tracker log were revised.</p> <p>On 02/26/2025 at 12:47 pm, the Surveyor interviewed the van driver via phone. The van driver stated that, at around 4:30 pm, he had picked up the Resident from the dialysis center. The van driver further stated, She/ He was in her wheelchair, put her in the vestibule, put on her/ his seatbelt, and she was fine and did not complain of any pain or discomfort. At 5:00 pm, we arrived at the facility parking lot; I parked the van where I normally parked. I exited the van and walked to the rear of the building. In my mind, I wanted to go back to the building to finish some work. When the Supervisor called me that night, it was shocking to me. I was emotional. I drove her [the Resident] on several occasions, and I think I was not focused at that time.</p> <p>On 02/26/2025 at 1:27 pm, the Surveyor placed a call to LPN #1 but did not receive a return call.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy titled: Policy: Elopements and Wandering Residents with review date: 5/15/24, under Policy Explanation and Compliance Guidelines: .5. Procedure for locating missing resident: a.Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol (code grey). b.The designated facility staff will look for the resident .</p> <p>A review of the facility's policy titled: Policy: Tracker for Residents Leaving the Building date revised 2/13/25, Under Procedure: 1. Receptionist will record Resident name, date, room number, name of person/transport company, destination, and time that resident leaves the building; 2. Receptionist will then send out an email to the LIVIA team informing staff that resident has left the building; 3. When the resident returns from the appointment, the receptionist will record the return time on the tracking log. The receptionist will also ask the driver to sign the tracking log to confirm that they brought the resident back into the building; 4. Receptionist will then send out an email to the LIVIA team informing staff that resident has returned; 5. If the resident does not return to the building within the expected duration, the receptionist will alert the nursing supervisor that the resident has not yet returned; 6. If the resident does not return to the building prior to reception change of shift, the receptionist will report to oncoming receptionist for continued follow up.</p> <p>A review of the facility's policy titled: Resident Transportation date revised 2/11/25, Under Procedure: .6. Resident Tracking Log is completed by receptionist. Driver signs tracking log upon return of resident. 7. Resident Transport Checklist is completed by [facility name] driver .</p> <p>N.J.A.C. 8:39-27.1(a)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>51144</p> <p>Complaint #: NJ00182762</p> <p>Based on interviews, medical record review, and review of other pertinent facility documents on 02/25/2025 and 02/26/2025, it was determined that the facility staff failed to consistently document in the Documentation Survey Report (DSR) the Activities of Daily Living (ADL) status and care provided to the residents. This deficient practice was identified for 1 of 3 residents (Resident #6) reviewed for ADL documentation. This deficient practice was evidenced by the following:</p> <p>According to the Admission Record (AR), Resident #6 was admitted to the facility with diagnoses that included but were not limited to: diverticulitis of large intestine without perforation or abscess without bleeding; gastrointestinal hemorrhage, unspecified; unsteadiness on feet; weakness; need for assistance with personal care; other reduced mobility; dementia in other diseases classified elsewhere, unspecified severity, without other behavioral disturbance; and Alzheimer's Disease with late onset</p> <p>A review of Resident #6's Minimum Data Set (MDS) dated , an assessment tool, revealed a Brief Interview of Mental Status (BIMS) score of 3 out of 15, which indicated that the resident's cognition was severely impaired. The MDS further revealed that the resident depended on a helper to eat and roll left and right.</p> <p>A review of Resident #6's Care Plan (CP) initiated on 10/01/2024 revealed that the resident was at risk for malnutrition due to Alzheimer's Disease, dementia, diverticulitis, and skin breakdown. The CP revealed that Resident #6 was at risk for skin impairment due to decreased bed mobility. Further review of the resident's CP revealed a Focus, initiated on 10/17/2024, that the resident was resistive to turning and positioning.</p> <p>A review of Resident #6's Documentation Survey Report (DSR) and progress notes (PNs) for the months of October and November 2024 revealed no documentation to indicate that the resident's activity of daily living (ADL) care was provided, or that the resident refused care on the following dates and times:</p> <p>Bed mobility:</p> <p>7:00 AM- 3:00 PM shift on: 10/01/2024, 10/03/2024, 10/04/2024, 10/05/2024, 10/07/2024, 10/10/2024, 10/11/2024, 10/12/2024, 10/13/2024, 10/14/2024, 10/22/2024, 10/24/2024, 10/25/2024, 10/28/2024, 10/29/2024, 10/30/2024, 10/31/2024, 11/03/2024, 11/04/2024, 11/05/2024, 11/06/2024, 11/07/2024, 11/11/2024, 11/12/2024, 11/13/2024, 11/14/2024, 11/15/2024, 11/16/2024,11/17/2024, and 11/18/2024.</p> <p>3:00 PM - 11:00 PM shift on: 10/01/2024, 10/02/2024, 10/03/2024, 10/05/2024, 10/06/2024, 10/15/2024, 10/18/2024, 10/29/2024, and 11/15/2024.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>11:00 PM - 7:00 AM shift on: 10/01/2024, 10/05/2024, 10/08/2024, 10/09/2024, 10/12/2024, 10/13/2024, 10/15/2024, 10/17/2024, 10/18/2024, 10/20/2024, 10/23/2024, 10/20/2024, 10/31/2024, 11/01/2024, 11/02/2024, 11/03/2024, 11/04/2024, 11/05/2024, 11/08/2024, 11/10/2024, 11/11/2024, 11/12/2024, 11/13/2024, 11/16/2024, and 11/17/2024.</p> <p>Eating:</p> <p>9:00 AM on: 10/01/2024, 10/03/2024, 10/04/2024, 10/05/2024, 10/07/2024, 10/11/2024, 10/11/2024, 10/12/2024, 10/13/2024, 10/14/2024, 10/22/2024, 10/24/2024, 10/25/2024, 10/28/2024, 10/29/2024, 10/30/2024, 10/31/2024, 11/03/2024, 11/04/2024, 11/05/2024, 11/06/2024, 11/07/2024, 11/11/2024, 11/12/2024, 11/13/2024, 11/14/2024, 11/15/2024, and 11/16/2024.</p> <p>1:00 PM on: 10/01/2024, 10/03/2024, 10/04/2024, 10/05/2024, 10/07/2024, 10/10/2024, 10/11/2024, 10/12/2024, 10/13/2024, 10/14/2024, 10/22/2024, 10/24/2024, 10/25/2024, 10/28/2024, 10/29/2024, 10/30/2024, 10/31/2024, 11/03/2024, 11/04/2024, 11/05/2024, 11/06/2024, 11/07/2024, 11/11/2024, 11/12/2024, 11/13/2024, 11/14/2024, 11/15/2024, and 11/16/2024.</p> <p>6:00 PM on: 10/01/2024, 10/02/2024, 10/03/2024, 10/05/2024, 10/06/2024, 10/15/2024, 10/18/2024, 10/29/2024, and 11/15/2024.</p> <p>Nutrition- amount eaten:</p> <p>9:00 AM on: 10/01/2024, 10/03/2024, 10/04/2024, 10/05/2024, 10/07/2024, 10/10/2024, 10/11/2024, 10/12/2024, 10/13/2024, 10/14/2024, 10/22/2024, 10/24/2024, 10/25/2024, 10/28/2024, 10/29/2024, 10/30/2024, 10/31/2024, 11/03/2024, 11/04/2024, 11/05/2024, 11/06/2024, 11/07/2024, 11/11/2024, 11/12/2024, 11/13/2024, 11/14/2024, 11/15/2024, and 11/16/2024.</p> <p>1:00 PM on: 10/01/2024, 10/03/2024, 10/04/2024, 10/05/2024, 10/07/2024, 10/10/2024, 10/11/2024, 10/12/2024, 10/13/2024, 10/14/2024, 10/22/2024, 10/24/2024, 10/25/2024, 10/28/2024, 10/29/2024, 10/30/2024, 10/31/2024, 11/03/2024, 11/04/2024, 11/05/2024, 11/06/2024, 11/07/2024, 11/11/2024, 11/12/2024, 11/13/2024, 11/14/2024, 11/15/2024, and 11/16/2024.</p> <p>6:00 PM on: 10/01/2024, 10/02/2024, 10/03/2024, 10/05/2024, 10/06/2024, 10/15/2024, 10/18/2024, 10/29/2024, and 11/15/2024</p> <p>During an interview with the surveyor on 02/25/2025 at 1:40 PM, the Certified Nursing Assistant (CNA) stated that the care provided should have been documented in the facility's electronic record each day by the end of the shift. The CNA further stated that residents who required assistance with bed mobility were repositioned every two hours.</p> <p>During an interview with the surveyor on 02/26/2025 at 3:20 PM, the Assistant Director of Nursing (ADON) stated that residents who needed repositioning were repositioned multiple times per day. The ADON stated that CNAs were responsible to document repositioning in the facility's electronic medical record. The ADON further stated that it was the expectation that CNAs completed documentation before the end of their shift. The ADON confirmed the presence of blank spaces on Resident #6's DSR. The ADON stated that if the DSR contained blank spaces, we don't know what care was given.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the surveyor on 02/26/2025 at 4:50 PM, the Director of Nursing (DON) stated that residents who needed repositioning were repositioned at the start and end of each shift, before and after meals, and every two hours on the night shift. The DON stated that CNAs were responsible for repositioning, but no direct care staff was able to do it. The DON further stated that it was the expectation that CNAs completed documentation in the electronic medical record before the end of their shift. The DON confirmed the presence of blank spaces on Resident #6's DSR. The DON stated that if the DSR contained blank spaces, there was no way to know if the care was provided or not.</p> <p>NJAC 8:39-35.2 (f)</p>		