

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 11/06/2025
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Complaint # 2656895 Based on interview, record review and review of other pertinent facility documents on 11/6/25, it was determined that the facility failed to ensure that the nursing services were provided and documented consistently on the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) in accordance with professional standards of practice. This deficient practice was identified for 1 of 4 residents reviewed for standards of practice (Resident #1). The evidenced was as follows: Reference: 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 otherwise legally authorized Physician or Dentist. A review of the facility's undated policy titled Charting and Documentation revealed that item 7 stated Documentation of procedures and treatments will include are-specific details, including: b) the name and title of the individual(s) who provide the care; g) the signature and title of the individual documenting. A review of the admission Record (AR) revealed that Resident #1 was admitted to the facility with diagnoses that included but were not limited to low back pain, depression, muscle weakness, and difficulty walking. A review Resident #1's comprehensive Minimum Data Set (MDS,) an assessment tool dated 7/17/25, revealed that the resident had a Brief Interview Mental Status (BIMS), of 15 out of 15, indicating that the resident's cognition was intact. A Review of the August 2025 Medication Administration Record (MAR) revealed blanks for the following medication orders: Normal Saline flush solution 0.9% (sodium chloride flush) use 10ml intravenously every 6 hours for flush before use on 8/11/25 at 0600. Normal Saline flush solution 0.9% (sodium chloride flush) use 10ml intravenously every 4 times a day for flush after use on 8/11/25 at 0630. A Review of the July 2025 TAR, revealed blanks for the following treatments: Skin assessment with bi-weekly showers scheduled every day shift for Tuesday, and Friday and document on 7/29/25 on the day shift. On 11/6/25 at 1:11PM an interview was conducted with the Director of Nursing (DON) who stated that the assigned nurse was responsible for signing the treatment record after each treatment completed. The DON further stated that the expectation is for the nurse to carry out the physician order and sign the treatment record, indicating that it is the only way to verify that the treatment has been completed. A review of the facility's policy titled Administering Medications with a reviewed date of 5/2/25 revealed under Procedure number 18 The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. NJAC 8:39-11.2(b)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 315529
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Complaint # 2656895 Based on interviews, medical record review, and review of pertinent facility documentation on 11/6/25 it was determined that the facility failed to consistently document Activities of Daily Living (ADL) as being provided to residents. This deficient practice was identified for 1 of 4 residents reviewed for ADLs (Resident #1).The findings were as followed: A review of the admission Record (AR) revealed that Resident #1 was admitted to the facility with diagnoses that included but were not limited to; depression muscle weakness, and difficulty walking. A review Resident #1's comprehensive Minimum Data Set (MDS,) an assessment tool dated 7/17/25, revealed that the resident had a Brief Interview Mental Status (BIMS), of 15 out of 15, indicating that the resident's cognition was intact. A review of the July 2025 Documentation Survey Report v2, for Activity of Daily Living (ADL) care by the Certified Nursing Assistants (CNAs), revealed blanks for the following: Bed mobility on 7/28/25 on the evening shift. On 7/31/25 on the night shift. Dressing on 7/28/25 on the evening shift. Personal hygiene on 7/28/25 on the evening shift. Toilet use on 7/28/25 on the evening shift. Walk in corridor on 7/28/25 on the evening shift. Walk in room on 7/28/25 on the evening shift. Bowel and bladder elimination on 7/28/25 on the evening shift.Eating on 7/28/25 at 6:00 PM, on the evening shift. Nutrition, amount eaten on 7/28/25 at 6:00 PM, on the evening shift On 11/6/25 at 1:23 PM, an interview was conducted with the Director of Nursing (DON) who revealed that the CNA was responsible for documenting on the Activity of Daily Living (ADL). The DON further revealed that the Assistant Director of Nursing (ADON) and the DON were responsible for auditing MAR, TAR, and ADL documentation to ensure completion. A review of the facility's undated policy titled ADL Documentation Policy revealed under Procedure in item number 2 Documentation Requirements revealed in section a) ADLs shall be documented in real time or immediately after completion of care tasks for each shift. NJAC 8:39, 27.2(b), (h).</p>