

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 09/20/2024
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824</p> <p>Based on observation, interview, record review, and policy review, the facility failed to ensure appropriate care of a gastrostomy tube (g-tube) during enteral feeding and medication administration for one resident (Resident (R) 178) of one resident reviewed during medication administration with g-tube. Specifically, Licensed Practical Nurse (LPN) 1 administered g-tube medications via push method rather than by gravity administration and failed to check for proper g-tube placement. This failure increases the risk for nausea, vomiting, or aspiration.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Enteral Nutrition revised 11/2018 did not include medication administration, but did include .Risk of aspiration is assessed by the nurse and provider and addressed in the individual care plan. Risk of aspiration may be affected by: .failure to confirm placement of the feeding tube prior to initiating the feeding .</p> <p>Review of the facility's policy titled Administering Medications through an Enteral Tube revised 11/2018 stated to prepare the resident by .verify placement of feeding tube .dilute medication: a. Remove plunger from syringe .11. Reattach syringe (without plunger) to the end of the tubing. 12. Administer medication by gravity flow: a. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion .</p> <p>Review of LPN1's Annual Competency training, provided by the facility, dated 09/14/23 included Gastrostomy (g-tube) Feedings which included checking the placement of the tube and hanging the prescribed feeding.</p> <p>Review of a document provided by the facility titled Attendance Record, dated 12/19/23 for an in-service related to Peg Tube [percutaneous endoscopic gastrostomy which is similar to a g-tube and requires the same in regard to checking of placement and administration of medications] included LPN1's signature. The document indicated LPN1 was educated verbally and performed return skill demonstrations related to peg tubes.</p> <p>Review of R178's undated Admission Record located in the electronic medical record (EMR) under the Profile tab indicated the resident was admitted to the facility on [DATE] with diagnoses which included peritoneal abscess, dysphagia, moderate protein-calorie malnutrition, acute pancreatitis, and gastrostomy status.</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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R178's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 09/10/24 and located in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R178 was cognitively intact. The MDS also revealed the facility assessed that R178 received nutrition via a feeding tube which provided greater than 51% of her daily nutritional needs.</p> <p>Review of R178's Care Plan located in the resident's EMR under the Care Plan tab included enteral nutrition support and administration of medications as ordered by the physician dated 09/04/24.</p> <p>Review of R178's Order Summary Report located in the EMR under the Orders tab included an order dated 09/04/24 for enteral feeding every four hours, check tube placement before initiation of formula or medication administration. Continued review revealed an order dated 09/04/24 for Nexium oral packet 40 milligrams (mg), give one packet via g-tube two times a day for gastroesophageal reflux disease (GERD) and saccharomyces boulardii (probiotic) 250mg, give one packet via g-tube two times a day for supplement. Flush tube with 30 milliliters (ml) of water before and after administration of medication pass.</p> <p>During an observation and interview on 09/19/24 at 3:58 PM revealed LPN1 prepared and administered R178's gastrostomy tube feeding at 50 ML per hour. LPN1 did not check placement of g-tube and used push method to administer 30 ML water flush prior to administration of the enteral feeding. R178 immediately asked for the emesis bag and complained of nausea.</p> <p>During an observation on 09/19/24 at 5:14 PM LPN1 prepared Nexium oral packet 40 mg. LPN1 could not prepare the ordered saccharomyces boulardii 250 mg packet because the medication was not available for R178. LPN1 verified the ordered saccharomyces boulardii with Unit Manager (UM) 1. The physician was notified, and the order was changed to acidophilus probiotic 10 mg capsule, give two capsules via g-tube BID. LPN1 paused the enteral feeding, checked for placement of the g-tube by injecting 5 ml of air into the tubing while listening with the stethoscope. LPN1 then checked for residual and flushed the g-tube with 30 ML via push method. Continued observation revealed LPN1 then administered Nexium via push method, flushed with 30 ML water via push method, administered acidophilus probiotic via push method, then flushed the g-tube with 30 ML via push method prior to reconnecting the enteral feeding.</p> <p>During an interview on 09/19/24 at 6:33 PM, UM1 stated it was her expectation nurses check for placement prior to enteral feedings and medication administration via g-tubes. Additionally, unless ordered by the physician, medications and flushes should be administered via gravity from the syringes for all g-tubes.</p> <p>During an interview on 09/19/24 at 7:00 PM, LPN1 confirmed she did not check for placement of R178's g-tube during enteral feeding administration at 4:58 PM because the resident's stomach would have been empty. When asked how she knew the g-tube was in place, LPN1 did not answer. LPN1 then stated she was in the habit of checking placement prior to medication administration. LPN1 confirmed she used the push method to administer medications instead of gravity because with the type of tube that R178 had, she had to do that in order for the medications to go through the tubing.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/20/24 at 7:44 PM, the Director of Nursing (DON) stated she was aware of the concerns and stated it was her expectation for nurses to confirm g-tube placement by listening with a stethoscope, listen for the gurgle, and pull back the syringe for residual volume. The DON also stated some doctors were very specific on residual volume and that would have been included in the order if the nurse should hold the feeding based on the excess residual. Medication administered via g-tube should be done via gravity; however, because R178's tube was special, the nurses had to do it extremely slow. The DON further stated the nurses had to administer medications via push method. After this surveyor notified UM1 of the concern on 09/19/24 of R178's nausea, the facility obtained an order for gravity administration.</p> <p>NJAC 8:39-27.1(a)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure proper cleaning and disinfecting of multi-use glucometer prior to blood glucose testing for one resident (Resident (R) 3) of two residents reviewed for blood glucose monitoring. This failure increased the risk for infection and transmission of blood borne pathogens.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Obtaining a Fingertick Glucose Level, revised 10/2011 revealed, . Steps in the procedure .Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses .If alcohol is used to clean the fingertip, allow it to dry completely because the alcohol may alter the reading .Obtain a blood sample by using a sterile lancet .Discard the first drop of blood if alcohol is used to clean the fingertips because alcohol may alter the results .</p> <p>Review of undated glucometer Cleaning and Disinfecting Procedures for the Meter provided by the facility stated, The EVENCARE ProView Meter should be cleaned and disinfected between each patient .Whenever your glucose meter is dirty, clean the outside of the meter with a new CaviWipes (effective surface disinfectant, effective against TB in 3 minutes, and HIV-1, HCV, HBV, and MRSA in 2 minutes) towelette or an EPA-registered disinfecting wipe .Disinfection Instructions: The meter must be disinfected between patient uses by wiping it with a CaviWipe towelette or EPA-registered disinfecting wipe in between tests and cleaned prior to disinfecting. The disinfection process reduces the risk of transmitting infectious diseases if it is performed properly .</p> <p>Review of Licensed Practical Nurse (LPN) 2's Annual Competency training provided by the facility and dated 10/02/23 included blood glucose testing and glucometer cleaning.</p> <p>Review of R33's undated Admission Record located in the resident's Electronic Medical Record (EMR) under the Profile tab revealed he was admitted to the facility on [DATE] with diagnoses which included type two diabetes mellitus without complications and long term (current) use of insulin.</p> <p>Review of R33's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/05/24 and located in the EMR under the MDS tab, revealed the MDS documented R33 had diabetes mellitus, had orders for insulin, and received insulin for seven days in the review period.</p> <p>Review of R33's Order Summary Report located in the EMR under the Orders tab included an order dated 08/30/24 of Humalog solution (insulin) 100 unit/ml (milliliter). Inject as per sliding scale (if reading from finger stick was): 200 - 250 = 20 units; 251 - 300 = 24 units; 301 - 350 = 28 units, subcutaneously with meals for diabetes mellitus.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 09/19/24 at 5:00 PM, LPN2 prepared to check R33's blood glucose by performing hand hygiene, donned gloves, cleansed R33's finger with an alcohol swab. The LPN then used a lancet to prick the resident's finger, obtained blood sample, and applied it to the glucometer strip; however, LPN2 did not wipe away the first drop of blood prior to applying the blood to the glucometer. LPN2 stated after she completed the test that she had forgotten to wipe away the first drop of blood, and forgot to wipe down the glucometer and let it dry prior to using for R33 but should have.</p> <p>During an interview on 09/20/24 at 3:38 PM, Unit Manager (UM) 2 provided a copy of Cleaning and Disinfecting Procedures for the Meter and confirmed the manufacturer's instructions were the expectation of the facility related to disinfecting glucometers between resident usage.</p> <p>During an interview on 09/20/24 at 7:44 PM, the Director of Nursing (DON) stated it was her expectation nurses disinfect glucometers before and after use for each resident due to risk for infection and transmission of pathogens.</p> <p>NJAC 8:39-19.4</p>		