STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livia Health and Senior Living	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 2/17/26 at 7:42 AM, in the presence of the Food Service Director (FSD), the surveyor observed the following:1. One dietary aide (DA#1) with facial hair not wearing a beard guard, two dietary aides (DA#2 and DA#3) wearing dangling earrings and DA#2 also wearing a dangling necklace. Per the FSD, all facial hair needs to be covered with a beard guard and any jewelry worn should not dangle.2. In the walk-in freezer, the surveyor observed two bags of French fries, two bags of hash browns and one package of lemon bars all opened without open or use-by labels. The FSD stated any food product that has been opened needs to have a label that indicates an open and/or use by date.3. In the walk-in refrigerator, the surveyor observed a clear container containing pineapple chunks, a 12-ounce (oz) jar of anchovies paste, a 32oz container of red salsa, and a plastic bag of fingerling potatoes, all had been opened without an open and/or use-by labels. The surveyor further observed three refrigerator fans with a blackish dust-like build up. The FSD stated every open container should be labeled, and the fans were scheduled to be clean that week.4. In the two-door refrigerated deli station, the surveyor observed a container of potato salad that was not labeled with a created and/or use by date.5. In the cooking area of the kitchen, the surveyor observed on top of two-door standing oven and standing steamer a buildup of a sticky substance. Per the FSD, all cooking equipment is cleaned weekly.6. On 2/18/26 at 11:08 AM, during the follow-up kitchen tour, the surveyor observed Chef #1 with facial hair not wearing a beard guard. The FSD spoke with Chef #1, and a beard guard was put on. On 2/19/26 at 8:30 AM, the Assistant Licensed Nursing Home Administrator (ALNHA) provided the surveyor with three facility policies. The culinary dress code policy with a reviewed date of 9/9/25 revealed, Required Attire: 1. All culinary staff must wear: d. [NAME] guard (if applicable) .Jewelry Restrictions. 1. Prohibited. b. Dangling earrings, c. Dangling necklaces. The culinary food labeling policy with a reviewed date of 6/15/25 revealed, General Labeling Requirements. 1. All prepared, opened, or repackaged food items must include: a. Name of the food items, b. Date prepared, or date opened, c. Use-by/discard/expiration date. The culinary sanitization policy with a reviewed date of 6/11/25 revealed, 3. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. On 2/19/26 at 12:52 PM, the surveyor met with the Chief Financial Officer (CFO), Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON) and ALHNA to review concerns found during the survey. The LHNA stated all concerns in the kitchen would be addressed immediately.On 2/20/26 at 11:37 AM, the surveyor met with the CFO, LNHA, ALNHA, DON and ADON for the exit conference. The LNHA provided copies of in-services for the kitchen concerns that were mentioned on 2/19/26. No further information provided. NJAC 8:39-17.2(g)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that a low-air-loss mattress was accurately set and monitored based on the resident's weight. This deficient practice was identified for 2 of 4 residents reviewed (Resident #9 and #12). This deficient practice was evidenced by the following: 1. On 2/18/26 at 11:00 AM, the surveyor observed resident #12 in bed with a specialty mattress in place. The resident's air mattress pump was set to a weight of 325 pounds.On 2/19/26 at 10:32 AM, the surveyor observed resident #12 in bed with a specialty mattress in place. The resident's air mattress pump was set to a weight of 325 pounds. The surveyor reviewed the medical record for Resident #12.A review of the admission record reflected that the resident was admitted to the facility on [DATE] with diagnoses that included but were not limited to; Parkinson's Disease (a progressive nervous system disorder that affects movement, caused by the loss of dopamine-producing brain cells) and diabetes mellitus (a chronic metabolic disorder characterized by high blood sugar). A review of the current Order Summary Report (OSR) included an active Physician's Order (PO) for air loss mattress; monitor function and placement every shift.A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 12/8/25, reflected that Resident #12 had a brief interview of mental status score of 15 of 15, which indicated Resident #12's cognition was fully intact. The MDS further noted that Resident #12 weighed 120 pounds and had a pressure-reducing device on their bed and chair. A review of Resident #12's monthly weights showed that the resident's most recent weight was 132 pounds.A review of Resident #12's current Treatment Administration Record (TAR) revealed the PO for an air loss mattress was transcribed onto the TAR with instructions to monitor for function and placement every shift, and was signed by the nurses every shift.A review of Resident #12's Care Plan Report identified a Focus area: a history of skin impairment, with interventions that included, but were not limited to, providing a pressure-reduction mattress (low-air-loss mattress) for the bed.On 2/19/26 at 11:00 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) confirmed that the specialty mattress was set at 325 pounds. The surveyor asked the LPN the resident's weight and whether the mattress should be set to that weight. The LPN replied that she was not sure of the resident's weight and that she had no idea what the specialty mattress should be set at because it was the maintenance department's responsibility to set it up and monitor it. The surveyor asked the LPN whether she had signed the TAR, indicating that it was being monitored. The LPN did not respond to the surveyor's inquiry.2. On 2/19/26 at 11:26 AM, the surveyor observed Resident #9 in bed on a specialty mattress. The surveyor observed that the resident's air mattress pump was set to a weight of 350 pounds. The LPN confirmed the pump was set to 350 pounds and again stated she had no idea what the mattress should be set at, as the maintenance department was fully responsible for the setup and monitoring of the specialty mattresses. The surveyor reviewed Resident #9's medical record. A review of the admission Record reflected that the resident was admitted to the facility on [DATE] with diagnoses that included but were not limited to diabetes mellitus and osteomyelitis (an infection of the bone).A review of the current OSR included an active PO Air loss mattress monitor function and placement every shift.A review of the quarterly MDS dated [DATE] reflected Resident #9 had a BIMS score of 15 of 15, which indicated Resident #9's cognition was fully intact. The MDS further reflected the resident's weight was 173 pounds, and the resident had a pressure-reducing device for their bed and chair. A review of Resident #9's monthly weights showed that the resident's most recent weight was 173.2 pounds.A review of Resident #9's current TAR revealed the PO for the air loss mattress, transcribed onto it, with instructions to monitor function and placement every shift, and was signed by the nurses.A review of Resident #9's Care Plan Report identified a Focus area indicating the resident had a history of skin impairment, with interventions that included, but were not limited to, providing a pressure-reduction mattress (low-air-loss mattress) for the bed.On 2/19/26 at (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:52 PM, the survey team met with the Licensed Nursing Home Administrator, Director of Nursing (DON), Administrator in Training, Chief Operations Officer, and Infection Preventionist Nurse to discuss the above observations and concerns. The DON confirmed that when the nurses signed the TARs, it indicated that they had been monitoring the specialty mattresses and ensuring they were set to the Resident's weight.On 2/20/26 at 9:20 AM, during an interview with the surveyor, the Director of Maintenance stated that the maintenance staff was responsible for setting up the specialty mattresses, and then the nurses monitored them.A review of the facility's policy: Support Surface Guidelines reviewed 7/2/25 reflected.The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown.The support surface will be adjusted per the resident's weight and physician's order.On 2/20/26 at 9:39 AM, no further information was provided. NJAC: 8:39 27.1 (a)

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on the interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS, an assessment tool used to facilitate the management of care) in accordance with federal guidelines. This deficient practice was identified for 3 of 18 residents (Resident #27, #50, and #91) during the review of resident assessment. This deficient practice was evidenced by the following: The MDS is a comprehensive tool, a federally mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of completing the assessment. After the MDS is transmitted, a quality measure will be transmitted to enable a facility to monitor the residents' decline or progress. On 2/17/26 at 11:30 AM, the surveyor provided the MDS Coordinator (MDSC) with the list of 3 residents who had not completed an MDS in over 14 days. The surveyor also requested a copy of the resident's final validation report (generated after every MDS transmission) from the Centers for Medicare and Medicaid Services (CMS). On 2/19/26 at 10:59 AM, the surveyor interviewed MDSC, she was aware that there were MDS assessments that were late. The surveyor reviewed the final validation report from CMS with the MDSC, the 3 residents' MDS assessments that were not submitted within fourteen days of completion, as follows: 1. Resident #27 had a Quarterly MDS assessment with an assessment reference date (ARD, the last day of the observation period) of 1/15/26 but was not transmitted until 2/22/26. (Submission was 24 days late). 2. Resident #50 had a Quarterly MDS assessment with an ARD, of 12/11/25 but was not transmitted until 1/28/26. (Submission was 33 days late). 3. Resident #91 had an Annual MDS assessment with an ARD, of 1/19/26 but was not transmitted until 2/11/26. (Submission was 9 days late.) On 2/19/26 at 11:50 AM, the surveyor reviewed policy titled, MDS-Completion and Submission Timeframe, dated, 9/25/25, which revealed.the assessments coordinator or designee is responsible for ensuring resident assessments are submitted to Center of Medicare and Medicaid Services' internet Quality Improvement Evaluation System (iQIES) in accordance with current federal and state guidelines. On 2/19/26 at 12:10 PM, the surveyor reviewed policy titled, MDS-Electronic Transmission, dated, 9/25/25, which revealed.all MDS assessments (admission, annual, significant change, quarterly review, discharge and reentry records are completed and electronically encoded into the facilities MDS information system and transmitted in accordance with current regulations governing the transmission of MDS data. On 2/19/26 at 12:56 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to review concerns found during the survey. The DON stated Admission, Quarterly and Annual MDS should be completed within 14 days of the ARD.On 2/20/26 at 12:06 PM, the surveyor team met with the LHNA and DON. No further pertinent information was provided.NJAC 8:39-11.1