STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335389	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livingston Hills Nursing and Rehabilitation Center	2781 Route 9 Livingston, NY 12541

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during an Abbreviated Survey (Complaint #NY00342787, #NY00355908, and #NY00348307) completed on [DATE], the facility did not maintain clinical records on each resident in accordance with accepted professional standards and practices, that were complete and accurately documented for three (3) (Resident #3, #4, and #5) of three (3) reviewed for medical records. Specifically, the facility transitioned to another electronic medical record company [DATE] and the facility did not have access to resident medical information for any residents that are current, discharged or expired prior to [DATE]. This is evidenced by: The facility policy titled Resident Medical Record dated 5/2025 documented the following: it is the policy of the facility to maintain Medical Records in accordance with State and Federal regulations. The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, systematically organized and include: Residents admissions and discharges; medical and general health status; personal and social history; identity and address of next of kin or responsible party; the resident's comprehensive care plan; results of any preadmission screening and resident review evaluations and determinations conducted by the State; Physicians, Nurses and other licensed professionals progress notes; and laboratory, radiology and other diagnostic services reports. The facility will retain medical records for the time period required by state law or five years from the date of discharge when there is no requirement in state law. The facility will safeguard clinical record information against loss, destruction or unauthorized use. Resident #3 had diagnoses including Neurocognitive disorder with Lewy bodies (a progressive brain disorder that causes a decline in thinking, reasoning and independent function), Alzheimer's disease (a type of dementia that affects memory, thinking and behavior), and Major Depressive Disorder (a mood disorder that causes a persistent feeing of sadness and loss of interest). The Minimum Data Set (a resident assessment tool) dated [DATE] documented Resident #3 was severely cognitively impaired. Resident #4 had diagnosis including Parkinson's Disease (a progressive movement disorder of the nervous system that worsens over time), dementia (the loss of cognitive functioning, thinking, remembering and reasoning to such an extent that it interferes with a person's daily life and activities), and depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). The Minimum Data Set, dated [DATE] documented Resident #4 was rarely / never understood and rarely / never understands. Resident #5 facility face sheet print date [DATE] had no documented diagnosis, and facility had no accessible medical information. A Medical Record review conducted [DATE] and [DATE] revealed there was no access to medical record information prior to [DATE] for Resident #3 and Resident #4; and there was no access to medical record information for Resident #5. During an interview on [DATE] at 9 AM, Administrator #1 stated they needed to contact Corporate Information Technology Nurse #1 to obtain medical record access for Resident #3, #4, and #5. During an interview on [DATE] at 2:45 PM, Director of Nursing #1 stated when the facility corporation changed the Electronic Medical Record Company Contract #1 to Electronic Medical Record Company Contract #2 in October or November of 2024, they realized they did not have access to the previous electronic medical record prior to [DATE] since approximately [DATE]. They stated they should have access to all medical record information for all residents that were admitted to the facility in the last five(5) years according to the regulations and for continuity for all residents currently residing in the facility that were admitted prior to [DATE] for continuity of care. During an interview on [DATE] at 2:54 PM, Administrator #1 stated the facility corporation changed the Electronic Medical Record Company Contract #1 to Electronic Medical Record Company Contract #2 in October or November of 2024 and their access to the electronic medical records from the previous company was taken away from them and the facility staff and had not identified this to be a concern. They stated they just did not think about the facility's need to always have access. Administrator #1 stated they were referring all additional questions concerning the lack of medical record access to Corporate Information Technology Nurse #1. During an interview on [DATE] at 11:23 AM, Corporate Information Technology Nurse #1 stated the facility changed to Electronic Medical Record Company Contract #2 [DATE] and did not know the facility did not have access to their residents electronic medical records from Electronic Medical Record Company Contract #1, until yesterday ([DATE]) when they were requested to provide access to the electronic medical record for the New York State Department of Health. They stated they were

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review conducted during an Abbreviated Survey (Compliant #NY00378346) completed on 7/14/2025, the facility did not ensure provision of a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for one (1) (Resident #1) of one (1) resident reviewed for infection control practices. Specifically, Resident #1 was on Enhanced Barrier Precautions (interventions designed to reduce transmission of multi-drug-resistant organisms including mask, gown and glove use during high contact resident care activities) and staff did not wear proper personal protective equipment while providing wound care and did not change gloves and wash hands according to standards of practice. This is evidenced by: The facility policy and procedure titled, Enhanced Barrier Precautions, revised 2/19/2025, documented the following: it is the policy of the facility to implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug-resistant organisms. Novel or targeted Multi Drug Resistant Organisms are organisms that are resistant to all or most antibiotics tested, are uncommon in a geographic area, or have special genes that allow them to spread their resistance to other germs. Enhanced Barrier Precautions are indicated for resident with any of the following: Infection or colonization with a Centers for Disease Control and Prevention (the national public health agency of the United States) - targeted Multi Drug Resistant Organism when Contact Precautions do not otherwise apply or wounds and / or indwelling medical devices even if the resident is not known to be infected or colonized with a Multi Drug Resistant Organism. Enhanced barrier precautions require the use of gown and gloves for certain residents during specific high-contact resident care activities in which there is an increased risk for transmission of multidrug resistant organisms. High-contact resident care activities include bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line care, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing. *Note to reader: Enhanced Barrier Precautions is an infection control strategy that uses targeted gown and glove use during high-contact resident care activities to reduce the transmission of multidrug-resistant organisms; it is a supplement to standard precautions and existing isolation guidelines, aiming to reduce the spread of microorganisms that can cause infections. The facility specific card (signage) for Enhanced Barrier Precautions, documented everyone must clean their hands, including before entering and when leaving the room, providers and staff must also: Wear gloves and gown for the following high-contact resident care activities included wound care. The facility policy and procedure titled, Hand Hygiene, dated 4/2024, documented the following: it is the policy of the facility to perform hand hygiene in accordance with national standards from the Centers for Disease Control and Prevention and the World Health Organization. The Centers for Medicare and Medicaid State Operations Manual indicates that hand hygiene should be performed in situation such as but no limited to: when moving from contaminated to clean when changing a brief or a wound dressing and after removal of gloves and prior to donning (applying) clean gloves. The facility policy and procedure titled, Dressing Change - Clean, revised 5/2025, documented the following: it is the policy of the facility to ensure dressings are changed in accordance with State and Federal Regulations, and national guidelines. Perform hand hygiene, put on clean gloves, remove dressing and place in the resident's trash can, remove gloves and perform hand hygiene, put on clean gloves, cleanse wound with gauze and prescribed cleanser, removed gloves and preform hand hygiene, put on clean gloves, apply clean dressing as ordered, remove gloves and perform hand hygiene, discard all disposable items into appropriate receptacle, remove trash from resident's room, wash and dry hands thoroughly. Resident #1 had diagnoses including non-pressure chronic ulcer (a sore on the skin that has failed to heal for an extended period, typically more than four (4) to six (6) weeks, despite appropriate treatment) of right lower leg, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and Anxiety Disorder (a group of mental heal conditions characterized by excessive, persistent and uncontrollable feelings of worry, fear, and unease, which can significantly impair daily functioning). The Minimum Data Set (a resident assessment tool) dated 6/20/2025 documented Resident #1 was cognitively intact, understood and understands, had a surgical wound and received antibiotics. Review of the comprehensive care plan titled Care Plan Activity Report identified as current by Director of Nursing #1 documented the following: Chronic skin condition chronic ulcer to right lower extremity requiring daily dressing changes dated 6/25/2025, interventions included: apply treatments as ordered; notes: dated

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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 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a Compliance and Ethics Program. Based on record review and interviews conducted during an Abbreviated Survey (Complaint #NY00342787, #NY00355908, and #NY00348307) completed on 7/14/2025, the facility did not effectively communicate and implement the standards of its compliance and ethics program that is likely to be effective in preventing care violations and promoting quality of care. Specifically, at a minimum, the facility did not implement the standards of its compliance and ethics program-resident medical records dated prior to November 2024 were not accessible. A risk area of record retention is associated with the delivery of health care to nursing facility residents. This could place all residents at risk of diminished quality of care. This is evidenced by: The facility policy titled, Compliance and Ethics Program, undated, identified as current by Administrator #1 documented the following: we are accountable and responsible for fulfilling out pledge to safeguard the welfare of each resident in a lawful and principled manor. The compliance and ethics program includes ongoing monitoring and auditing to assess compliance. The facility provides services that assist each resident in attaining or maintaining his or her highest practicable physical, mental, and psychosocial well-being. The facility requires the retention of all generated and received recorded information, electronic and paper, related to financial, medical, or legal issues for the applicable period required by law. All records should be kept in their original form or a suitable alternative form for storage for the duration of the period at which time such records should be destroyed in the event of legal hold notice, requiring retention of certain records that may be relevant to matters that are subject of litigation, investigations, or audits is issued, the terms of such notice should be carefully observed, superseding normal document retention practices. During an interview on 7/11/2025 at 10:45 AM, Administrator #1 stated they were the Corporate Compliance Officer for the facility and were responsible for the oversight of all facility compliance with regulations and adherence to legal and ethical standards. The stated they were aware the facility did not have access to all their resident's electronic medical records from the previous electronic medical company for all residents admitted prior to November 2024 but did not identify it was a concern, and they should have. They stated they had not discussed the lack of medical record accessibility with the Corporate Compliance Committee or the Quality Assurance Performance Improvement Committee and should have. Additionally, they stated they had not voiced a concern to the Corporate Information Technology Nurse #1 because they believed they were aware because they were in charge of the transitioning the medical records from the previous electronic medical record company to the present electronic medical records company and they should have identified this as a concern and informed them. Administrator #1 stated they were responsible to have ensured the facility Corporate Compliance Program was effective. During an interview on 7/11/2025 at 11:23 AM, Corporate Information Technology Nurse #1 stated they would have expected Administrator #1 to have informed them if they were unable to access the previous electronic medical records for all their residents for continuity of care. During an interview on 7/11/25 at 12:50 PM, Operator #1 stated they would have expected the Corporate Compliance Officer who is Administrator #1 to have informed Corporate Information Technology Nurse #1 if they identified they needed to access the records. 10 New York Codes, Rules and Regulations 415.26(b)(3)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews conducted during an Abbreviated Survey (Compliant #NY00378346) completed on 7/14/2025, the facility did not ensure an effective training program for all new and existing staff was developed, implemented and maintained based on the facility assessment for two (2) of two (2) staff (Licensed Practical Nurses #1 and #3) reviewed. Specifically, there was no documented evidence Licensed Practical Nurses #1 and #3 had peripheral intravenous training and competencies and they administered antibiotics via peripheral intravenous to Resident #2. This is evidenced by: The Facility Assessment Tool completed 4/23/2025, documented the following: Medication awareness of any medications that residents need, by route including intravenous) peripheral or central lines). Facility resources needed to provide competent support and care for our resident population every day and during emergencies included staff training / education and competencies for medication administration and specialized care. The facility policy and procedure titled, Core Competencies, dated 6/12/2024, documented the following: the facility will have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. This will be met by documented competency evaluation upon hire, annually, with the introduction of new equipment or services, and as needed. The facility will ensure that licensed nurses have the specific competencies, and skill sets necessary to care for residents' needs. The New York State Education Department Office of the Professions website dated 7/10/2025 documented the following: New York's Nurse Practice Act allows Licensed Practical Nurses to provide Intravenous Therapy services only if the Licensed Practical Nurse is appropriately trained and clinically competent to do so. New York law requires intravenous training for Licensed Practical Nurses who provide intravenous therapy in hospitals, nursing homes diagnostic and treatment centers, ambulatory surgery centers, dialysis facilities, home care agencies, and hospice programs. The training must include supervised clinical experiences and competency assessments. Licensed Practical Nurses must complete additional intravenous training at least annually. Resident #2 had diagnoses including osteonecrosis of the jaw (a severe bone disease that involves the death of jawbone cells), Major Depressive Disorder (a mood disorder that causes a persistent feeing of sadness and loss of interest), and muscle weakness. The Minimum Data Set (a resident assessment tool) dated 6/24/2025 documented Resident #2 was cognitively intact, could be understood and understands others. Review of the comprehensive care plan titled, Care Plan Activity Report, identified as current by Director of Nursing #1 documented the following: Infection - osteonecrosis of jaw dated 6/05/2025, interventions included: administer medications as ordered, monitor for signs and symptoms of side effects of antibiotics. Review of the Physician Orders identify as current by Director of Nursing #1 documented the following: Dated 7/03/2025 Ceftriaxone (an antibiotic used to treat a wide variety of bacterial infection), two (2) grams solution for injection by intravenous route once daily for six (6) weeks. Review of the Medication Administration Record dated July 2025 documented the following: Ceftriaxone two (2)-gram solution for injection by intravenous route once daily for six (6) weeks start date 7/04/2025. Medication initialed as administered by the following nurses:-Dated 7/05/2025 and 7/06/2025 at 9 AM by Licensed Practical Nurse #1-Dated 7/07/2025 and 7/08/2025 at 9 AM by Licensed Practical Nurse #3 Nursing Staff Education folders and Employee Personnel Folders reviewed and revealed the following:-Licensed Practical Nurse #1, did not have documented evidence of facility education and competency for peripheral intravenous medication administration and care. -Licensed Practical Nurse #3, did not have documented evidence of facility education and competency for peripheral intravenous medication administration and care. During an interview on 7/10/2025 at 7:52 AM, Licensed Practical Nurse #3 stated they administered the peripheral intravenous antibiotic to Resident #2 on 7/07/2025 and 7/08/2025. They stated the last received peripheral intravenous education in 1976. They stated they were not intravenous certified and had not had any peripheral intravenous education and competency evaluations completed annually. During an interview on 7/10/2025 at 8:23 AM, Director of Nursing #1 stated Licensed Practical Nurses were allowed to hang peripheral intravenous antibiotics after the first dose of antibiotic administered by a Registered Nurse and Licensed Practical Nurses should have peripheral intravenous education and competencies in their education or personnel files. Upon review of Licensed Practical Nurse #1 and #3 facility education and competencies, they stated they are unable to verify the facility provided peripheral intravenous education and