

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335389	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2026
NAME OF PROVIDER OR SUPPLIER Livingston Hills Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Potential for minimal harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during a survey, the facility failed to ensure medical records on each resident were complete and accurately documented for seven (Residents #s 1,2,3,4,5,6 and 7) of seven residents reviewed. Specifically, Certified Nurse Aides tasks were not documented daily during February 2026. This lack of accurate record keeping made it difficult for other staff to know which tasks were completed for residents and what level of assistance was provided. Findings include: Facility Policy and Procedure titled Certified Nurse Aide Documentation, last revised 09/2025, stated documentation of activities of daily living performance will be maintained in the Certified Nurse Aide record area of the electronic medical record. The purpose of documentation was to provide ongoing documentation of the resident's receipt of daily unskilled services and participation, level of support, in addition to other functional and observational data for continuity of record and accuracy of assessment, and to provide accurate data for care planning and medical decision-making. Certified Nurse Aides are expected to document the following items in the electronic medical record each shift: bathing/showers, toileting/bowel movements, eating/meal consumption, dressing, transfers, bed mobility, ambulation, skin condition, safety interventions. It is the responsibility of the Certified Nurse Aide to document care provided for residents upon/following provision of care by Certified Nurse aide but no later than the end of the shift. Resident #1 Resident #1 was admitted to the facility with the diagnoses displaced intertrochanteric fracture of the right femur (a type of broken hip occurring in the upper region of the thigh bone), unspecified dementia (when a person has a clear cognitive decline consistent with dementia, but cannot definitively identify the type of dementia), and muscle weakness. The Minimum Data Set (a resident assessment tool) dated 11/12/2025, documented the resident could be understood, understood others, and had severe cognitive impairment. The Comprehensive Care Plan with focus Activities of Daily Living effective 11/14/2025, documented the resident had self-care deficit in the following areas and the level of assistance needed: Bathing- extensive assist times one (when a person needs direct, hands-on weight-bearing physical help from one person to perform an activity); Bed Mobility- extensive assist times one Dressing- extensive assist times one Eating- set up Personal Hygiene- extensive assist times one Toilet Use- Extensive assist times bed level. Incontinent of bowel and bladder Transfer extensive assist times two (when a person needs direct, hands-on weight-bearing physical help from two people to perform an activity). Record Review of Resident #1's Certified Nurse Aide Documentation Record for February 2026 included tasks such as bed mobility, dressing, locomotion on unit, personal hygiene, transfer, eating, toilet use, Certified Nurse Aide Care provided, and skin check/care. Tasks were to be recorded on the shift they were performed, along with the level of support provided or if the task was self-performed. There was no documentation on the Certified Nurse Aide Documentation Record indicating when these tasks were performed and what level of assistance was provided for the following dates: 02/02/2026, 02/03/2026, and 02/05/2026. Resident #1 was discharged from the facility on 02/13/2026. Resident #3 Resident #3 was admitted to the facility with the diagnoses of unspecified dementia, unspecified severity, with agitation (cognitive decline without a defined subtype or stage, accompanied by (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 335389	If continuation sheet Page 1 of 3

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Many	behavioral symptoms like pacing, restlessness, or physical aggression), hypertension (high blood pressure), and adult failure to thrive (a syndrome characterized by unexplained weight loss, poor appetite, inactivity, and social withdrawal). The Minimum Data Set, dated [DATE], documented the resident could be understood, understood others, and had severe cognitive impairment. The Comprehensive Care Plan with focus Activities of Daily Living effective 11/07/2024, documented the resident had self-care deficit in the following areas and the level of assistance needed: Bathing- Maximal assist times one (when a person performs 25 percent or less of the effort needed for a task, while one caregiver provides 75 percent or more of the physical lifting, guiding, or balancing) Bed Mobility- Limited assist times one (when a person requires physical, hands-on help from one caregiver. The person performs most of the effort, while the caregiver performs non-weightbearing assistance) Dressing- Maximal Assist times one Eating- Maximal Assist times one Personal Hygiene- Maximal Assist times one Toilet Use- Maximal Assist times one; Transfer Limited assist times one, Rolling Walker. Record Review of Resident #3's Certified Nurse Aide Documentation Record for February 2026 included tasks such as bed mobility, dressing, locomotion on unit, personal hygiene, transfer, eating, toilet use, Certified Nurse Aide Care provided, and skin check/care. Tasks were to be recorded on the shift they were performed, along with the level of support provided or if the task was self-performed. There was no documentation on the Certified nurse Aide Documentation Record indicating when these tasks were performed and what level of assistance was provided for the following dates: 02/01/2026, 02/02/2026, 02/04/2026, 02/05/2026, 02/07/2026 through 02/15/2026, 02/17/2026, 02/18/2026, 02/20/2025, 02/22/2026 through 02/25/2026, 02/27/2026, and 02/28/2026. Resident #4 Resident #4 was admitted to the facility with diagnoses of diabetes mellitus, type two (a chronic condition where the body either resists the effects of insulin or does not produce enough to maintain normal glucose levels), chronic obstructive pulmonary disease (a progressive, inflammatory lung disease that restricts airflow and causes breathing difficulties), and congestive heart failure (a chronic condition where the heart does not pump blood as efficiently as it should leading to fluid retention in the lungs and body). The Minimum Data Set, dated [DATE], documented the resident could be understood, understood others, and had intact cognition. The Comprehensive Care Plan with focus Activities of Daily Living, effective 01/24/2025, documented the resident had self-care deficit in the following areas and the level of assistance needed: Bathing/shower- Extensive times one Bed Mobility- Extensive times one for rolling and total dependent to sit up Dressing- Extensive times one Eating- Set-Up and Supervision Personal Hygiene- Extensive times one Toilet Use- Extensive times one Transfer - Dependent times two Mechanical Lift Record Review of Resident #3's Certified Nurse Aide Documentation Record for February 2026 included tasks such as bed mobility, dressing, locomotion on unit, personal hygiene, transfer, eating, toilet use, Certified Nurse Aide Care provided, and skin check/care. Tasks were to be recorded on the shift they were performed, along with the level of support provided or if the task was self-performed. There was no documentation on the Certified Nurse Aide Documentation Record indicating when these tasks were performed and what level of assistance was provided for the following dates: on 02/01/2026 through 02/05/2026, 02/07/2026 through 02/10/2026, 02/13/2026 through 02/15/2026, 02/17/2026, 02/18/2026, 02/20/2026, 02/22/26 through 02/25/2026, 02/27/2026 and 02/28/2026. Interviews: During an interview on 03/10/2026 at 1:46 PM, Certified Nurse Aide #1 stated they documented in a resident's electronic healthcare record when they provided services for a resident. They tried to get their documentation in throughout the day, but sometimes the unit was a little hectic and they completed their documentation by the end of the day. They stated the certified nurse aide that had the resident on their assignment should be the one completing the documentation for that resident. During an interview on 03/10/2026 at 3:17 PM, Certified Nurse Aide #2 stated there were days they were not able to document when they provided care for the residents in the electronic health system because of other responsibilities they had. They stated they put the residents first; they were doing their job, but they were not able to get the documentation done. During an interview on 03/10/2026 at 3:46 PM, (continued on next page)		

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Many	Registered Nurse #1 stated certified nurse aide charting (documentation) was not always up to date and at times, they had to ask the certified nurse aides if residents had bowel movements, but if they were gone for the day they were not able to ask them. They stated they had to go by whatever was documented. During an interview on 03/11/2026 at 1:55 PM, Certified Nurse Aide #3 stated they completed documentation for everyone that was on their assignment. Areas they documented on included the percentage of what the resident ate and drank, care provided for completion of activities of daily living, and assistance with toileting. They completed their documentation during a break or at the end of their shift, and they still had to document for the person if their status was independent for those areas. They stated sometimes there was a shortage of staff and they did not have time to document. During an interview on 03/11/2026 at 2:03 PM, Registered Nurse #2 stated certified nurse aides were supposed to document the care they provided for the residents each day and it was supposed to be done for every resident on each shift, but it was not happening. They stated Director of Nursing #1 said they have a big problem with documentation. Registered Nurse #2 was able to look in the computer system and see that certified nurse aides were not documenting care provided to the residents. They stated if there was no documentation, they would not know if the residents had changes. During an interview on 03/11/2026 at 2:15 PM, Director of Nursing #1 stated certified nurse aides should have been documenting on everything they did with the resident and if the resident was independent in status, they were still responsible to document on them. They stated their priority was providing hands on care as opposed to documentation. They also stated any staff should have been able to look in a resident's chart and see the level of care that was provided. Documentation told a story, and if the story was not there, it could cause issues and the communication piece the documentation provided was important. Ideally, the certified nurse aides would document the care they provided in real time, but if they were short staffed, the priority was to get the care done and then document when they had a chance to sit down. They stated they did not know if the nurses spoke with the certified nurse aides about not completing their documentation on care provided for the residents. During an interview on 03/11/2026 at 2:43 PM, Administrator #1 stated staff did not document as well as they would like, but they were providing education to increase clinical competencies. Staff should be documenting on the care they provided as it was a requirement of their job. If there was a lack of documentation, it could not be proven care was provided. They stated the care for the residents was getting done, but the documentation of the care was not what it should be. 10 New York Codes of Rules and Regulations 415.22 (a)(1-4)		