STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315479	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	**68 PASSAIC AVENUE LIVINGSTON, NJ 07039**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ00154618 Census: 70 Sample size: 3 The facility is not in compliance with the requirements of 42 CFR Part 483 Subpart B for Long Term Care facilities based on this complaint survey.	F 000		
F 837 SS=D	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: C#: NJ00154618 Based on interviews, and record review, as well as review of pertinent facility documentation on 5/12/22, it was determined that the facility failed to consistently implement their policy on Charting and Documentation for 2 of 3 residents (Resident #1 and #2) reviewed for documentation. This	F 837	F837 Governing Body It is the practice of the facility to consistently implement the policy on Charting and Documentation. •Resident 2 and 3 POC have blanks in multiple dates and shifts with no signatures for the months of April and	6/6/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/26/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 837	Continued From page 1 deficient practice is evidenced by the following: 1. According to the "ADMISSION RECORD (AR)", Resident #1 was admitted to the facility on [NJAC 8:43E-2.1 an], with diagnoses that included but were not limited to: [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] The Minimum Data Set (MDS) an assessment tool dated [NJAC 8:43E-2.1 an], Resident #1's [NJAC 8:43E-2.1 and Ex] was [NJAC 8:43E-2.1 and Ex] and required [Ex.Order 26.4(b)(1)] from staff with Activities of Daily Living (ADL). The Care Plan (CP), dated 3/22/22, showed that Resident #1 had [NJAC 8:43E-2.1 and Exec Order 2] deficit related to [Ex.Order 26.4(b)(1)]. The "Documentation Survey Report v2 [Version 2] (DSR)" for the month of 4/2022 and 5/2022, and the progress notes (PN) showed no documented evidence by staff was completed about Resident #1 assistance with ADLs on the following dates and shifts which was not according to their policy. The facility policy describes how staff should document about rendering care and services to residents. On Bed Mobility and Dressing the following dates and shifts were blank as evidenced by: During 7:00 am-3:00 pm shift on 4/2/22, 4/7/22, 4/14/22 to 4/17/22, 4/21/22, 5/7/22, and 5/8/22. During 3:00 pm-11:00 pm shift on 4/1/22, 4/16/22, 4/18/22, 4/21/22, 4/27/22, and 5/6/22 During 11:00 pm-7:00 am shift on 4/11/22, 4/25/22, and 5/9/22 On Personal Hygiene the following dates and	F 837	May, for Bed Mobility, Personal Hygiene and Toilet Usage, documentation need to be completed when task have been completed. Residents were assessed and no negative outcomes identify. •Residents have the potential to be affected by this practice, documentation need to be completed when task have been completed. A baseline audit was completed by the Director of nursing of residents of the facility to review compliance with task documentation. •Policy and procedure in Charting and Documentation was reviewed and updated. Compliance with the policy will be monitored by the Governing Body. •CNAs were provided with additional education by the facility educator and nursing leadership related to appropriate documentation of task in the POC part of the medical record. •Unit Manager and supervisors were in-service on the updated policy and the importance of monitoring completion of documentation by rounding and using the resources available in Point Click Care. •Director of Nursing and nursing team will continue to monitor POC task documentation daily for 4 weeks, the monthly times x 2 months. •The DON will forward the results of the audits to the Administrator for submission and review by the Quality Assurance and Performance Improvement Committee for review monthly at the Quality Assurance and Performance Improvement. The results of these audits will be submitted monthly by the DON to Quality Assurance	

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F 837	Continued From page 2 shifts were blank as evidenced by: During 7:00 am-3:00 pm shift on 4/2/22, 4/7/22, 4/14/22 to 4/17/22, 4/21/22, 5/7/22, and 5/8/22. During 3:00 pm-11:00 pm shift on 4/1/22, 4/16/22, 4/18/22, 4/21/22, 4/27/22, and 5/6/22 On Toilet Use the following dates and shifts were blank as evidenced by: During 3:00 pm-11:00 pm shift on 4/1/22, 4/18/22, 4/21/22, 4/27/22 During 11:00 pm-7:00 am shift on 4/11/22 and 4/25/22 2. According to the AR, Resident #2 was admitted to the facility on [redacted], with diagnoses that included but were not limited to: [redacted] The MDS dated 5/2/22, Resident #2's cognition [redacted] and required [redacted] from staff with ADL. The CP dated 3/22/22, showed that Resident #2 had ADL [redacted] related to [redacted] The DSR and the PNs for the month of 5/2022 showed no documented evidence by staff was completed about Resident #2 assistance with ADL on the following dates and shifts which was not according to their policy. The facility policy describes how staff should document about rendering care and services to residents. On Bed Mobility, Dressing, and Toilet use the following dates and shifts were blank as evidenced by:	F 837	and Performance Improvement (QAPI) committee for a period of three months. Upon review, the QAPI Committee will review and determine revision to the plan if needed and reported the findings and corrections to the Governing Body.	

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F 837	Continued From page 3 During 3:00 pm-11:00 pm shift on 5/10/22 During 11:00 pm - 7:00 am shift on 5/2/22 On Personal Hygiene the following date was blank as evidenced by: During 3:00 pm-11:00 pm shift on 5/10/22 The surveyor conducted an interview with Certified Nursing Assistant (CNA #1) on 5/12/22 at 3:45 pm. The CNA stated that CNAs should document care provided to the Resident to indicate that it was done. The surveyor conducted an interview with the Nurse Supervisor (NS #1) on 5/12/22 at 11:50 am. The NS stated that CNAs should document and the NS should ensure that they document to indicate that the care was provided to the residents. The Job Description for Nurse Supervisor, dated 2003, showed "The primary purpose of your position is to supervise the date-to-day nursing activities of the facility during your tour of the duty. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing Services, to ensure that the highest degree of quality care is maintained at all times...As Nurse Supervisor you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties...Ensure that all nursing service personnel comply with the procedures set forth in the Nursing Service Procedure Manual...Ensure that all nursing service personnel are in compliance with their respective job	F 837		

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F 837	Continued From page 4 descriptions..." The facility's policy titled "Charting and Documentation" edited on 2/27/2018, showed "Policy Statement All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care...1. Documentation in the medical record may be electronic, manual or a combination..." NJAC 8:39-27.1(a)	F 837		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315479 Y1	A. Building B. Wing Y2	6/10/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT LIVINGSTON	68 PASSAIC AVENUE LIVINGSTON, NJ 07039

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0837 Reg. # 483.70(d)(1)(2) LSC	Correction Completed 06/06/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/12/2022

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**