STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07019	A. BUILDING: _____ B. WING _____	C 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT LIVINGSTON ASSISTED LIVING	**68 PASSAIC AVE. 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) COMPLETE DATE
A 000	Initial Comments Initial Comments: Type of Survey: Standard with Complaint Complaint #: NJ 00188410 Census: 22 Sample Size: 6 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice.	A1073		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07019	A. BUILDING: _____ B. WING _____	C 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT LIVINGSTON ASSISTED LIVING	68 PASSAIC AVE. 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) COMPLETE DATE
A1073	Continued From page 1	A1073		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined that the facility failed to ensure a Registered Nurse (RN) documented a follow up assessment of [NJ Ex Order 26. 4B1] in the medical record (MR) for 1 of 6 residents reviewed. [NJ Ex Order 26. 4B1] This deficient practice was evidenced by the following:

On 8/5/25 at 12:55 p.m., the surveyor reviewed Resident #5's MR which revealed that the resident moved into the facility in [NJ Ex Order 26. 4B1] .

In addition, the surveyor reviewed the resident "Progress Notes (PN)" dated [NJ Exec Order 26.4] at 9:32 p.m., written by a Licensed Practical Nurse (LPN). The LPN documented that this writer was called by a Care Partner (CP) at 4:45 p.m., to report [NJ Ex Order 26. 4B1] on Resident #5's [NJ Ex Order 26. 4B1] . The LPN also documented that the CP was unaware of how the resident obtained the [NJ Ex Order 26. 4B1].

Further surveyor review of the MR, revealed that there was no documentation indicating that an RN assessment was completed following the [NJ Exec Order 26.], [NJ Ex Order 26. 4B1].

On 8/6/25 at 10:32 a.m., the surveyor interviewed the Director of Nursing (DON) regarding the resident's [NJ Ex Order 26. 4B1]. The DON stated that the [NJ Ex Ord] was an unwitnessed incident and was investigated. In addition, the DON stated that she completed an assessment, of the [NJ Ex Ord] in the resident MR. The surveyor then pointed out to the DON that the assessment was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07019	A. BUILDING: _____ B. WING _____	C 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT LIVINGSTON ASSISTED LIVING	**68 PASSAIC AVE. 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) COMPLETE DATE
A1073	Continued From page 2 completed on 8/6/25 at 4:03 a.m., on survey date. The surveyor reviewed the facility policy titled, "Accident/Incident Reporting" which revealed "...The Registered Professional Nurse must be informed of all accidents or incidents so that medical attention can be provided. ...The Registered Professional Nurse shall: ...Examine all accidents/incident victims; ...The Registered Professional nurse must document the incident ..."	A1073		

8/20/25
Rc'd
accepted
8/28/25
NJ Ex Order 26. 4B1

Plan of Correction
CareOne at Harmony Village at Livingston
Survey Date: 8/6/2025

Plan of Correction: A1073

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   - Resident #5 was assessed by the RN, Director of Nursing on NJ Exec Order 26 with a late entry recorded 8/6/25.
   - Resident #5 had NJ Exec Order 26.4b1 related to this practice.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice.**

   - All residents have the potential to be affected by this practice.

3. **What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.**

   - On 8/6/25 the Regional Director of Clinical Services provided in-service education to the Director of Nursing (DON) on the policy, "Accident/Incident Reporting." Education included but was not limited to the "Registered Nurse shall...examine all accidents/incident victims;...the Registered Professional Nurse must document the incident..."
   - On 8/6/25 the Regional Director of Clinical Services and the Director of Nursing conducted an audit of all incident reports that occurred in the last 30 days to ensure the Registered Nurse examined and documented all incidents. There were no untoward findings.

4. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.?**

   - The Executive Director (ED) or designee will conduct audits of 50% of accident/incident reports weekly to ensure the Registered Nurse examined residents post incident and documented the assessment in the medical record.
   - Audits will be conducted weekly x 4 weeks, then monthly x 3 months.
   - The results of the audits will be forwarded to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 3 months. The QAPI Committee will review and provide recommendations for follow up or further audits as needed.

5. **Completion date** 8-20-25

NJ Ex Order 26. 4B1

accepted
8/28/25
NJ Ex Order 26. 4B1

POC Respectfully Submitted 8/20/2025 NJ Exec Order 26.4b1 **, Executive Director**

9/28/25 accepted

CareOne at Livingston Assisted Living

Plan of Correction
CareOne at Harmony Village at Livingston
Survey Date: 8/6/2025

Plan of Correction: A1073

1. **How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

    - Resident #5 was assessed by the RN, Director of Nursing or [redacted] with a late entry recorded 8/6/25.
    - Resident #5 had [redacted] related to this practice.

2. **How the facility will identify other residents having the potential to be affected by the same deficient practice.**

    - All residents have the potential to be affected by this practice.

3. **What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.**

    - On 8/6/25 the Regional Director of Clinical Services provided in-service education to the Director of Nursing (DON) on the policy, "Accident/Incident Reporting." Education included but was not limited to the "Registered Nurse shall...examine all accidents/incident victims;...the Registered Professional Nurse must document the incident..."
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    - The Executive Director (ED) or designee will conduct audits of 50% of accident/incident reports weekly to ensure the Registered Nurse examined residents post incident and documented the assessment in the medical record.
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- The results of the audits will be forwarded to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 3 months. The QAPI Committee will review and provide recommendations for follow up or further audits as needed.

5. **Completion date _____.**

POC Respectfully Submitted 8/20/2025, [redacted] **Executive Director**

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07019	A. BUILDING: _____ B. WING _____	R-C 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT LIVINGSTON ASSISTED LIVING	**68 PASSAIC AVE. LIVINGSTON, NJ 07039**

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/28/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
07019 Y1	A. Building B. Wing Y2	8/6/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT LIVINGSTON ASSISTED LIVING II	68 PASSAIC AVE. LIVINGSTON, NJ 07039

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 A1073 Reg. # 8:36-15.6(b) LSC	Correction Completed 08/20/2025	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 8/6/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
07019 Y1	A. Building B. Wing Y2	8/6/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT LIVINGSTON ASSISTED LIVING II	68 PASSAIC AVE. LIVINGSTON, NJ 07039

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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 8/6/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			