

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Livingston Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 348 E Cedar Street Livingston, NJ 07039	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Complaint#: 437202Based on facility policy review, record review, and staff interview, the facility failed to ensure one Resident (R) R3 out of a total of 17 residents reviewed in the sample was provided with appropriate quality of care (QOC) related to intravenous (IV) antibiotic medication administration. This failure created the potential for the residents to experience a negative change in physical status related to medication not being provided timely. Review of the facility's policy titled, Unavailable Medication Policy dated adopted 06/2021 revealed, In conjunction with the contracted pharmacy, the facility will make every effort to ensure a medication ordered for the resident is available to meet their needs; and In the event that a medication ordered for a resident is noted to be unavailable near or at the time it is to be dispensed, nursing staff shall: a. Contact the pharmacy regarding the unavailable medication. b. Attempt to obtain the medication from the facility's automated medication dispensing system or emergency kit. c. Notify the physician of the unavailable medication, explain the circumstances, report the date of expected availability, and provide the alternative medication(s) recommended by pharmacy. i. Obtain a new order and discontinue prior order, or ii. Obtain a hold order for unavailable medication. d. Notify the pharmacy, if applicable. Review of R3's admission Record found in the Electronic Medical Record (EMR) under the Profile tab, indicated the resident was admitted to the facility on 05/20/25 and discharged in 06/2025. The document indicated the resident's diagnoses included end stage renal disease (ESRD), Parkinson's Disease, type 2 diabetes, bone/joint infection. Review of R3's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/27/25 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. The assessment revealed R3's Primary Medical Condition related to her admission to the facility was osteomyelitis (bone infection) of vertebra, sacral, and sacrococcygeal region and revealed the resident was receiving antibiotic medication at the time of the assessment. Review of R3's Progress Notes dated 05/20/25 and found in the EMR under the Notes tab, revealed R3 was admitted on that date with an admitting diagnoses of sacral osteomyelitis secondary to a wound on her sacrum and excision of her sacral wound. The note indicated R3 did not have an IV line in place at the time of their admission to the facility. Review of R3's Physicians Orders dated 05/21/25 and found in the EMR under the Orders tab, revealed orders for the resident to receive Cefazolin (a potent intravenous (IV) antibiotic medication) one gram IV every morning for bone/joint infection. The resident's physicians orders revealed the order for R3's Cefazolin was discontinued and re-ordered to begin the following day on 05/21/25, 05/22/25, 05/23/25 and 05/24/25. Review of R3's Medication Administration Record (MAR) dated 05/20/25 through 05/31/25 and found in the EMR under the Orders tab, revealed R3 did not receive Cefazolin ordered on 05/21/25, 05/22/25, 05/23/25 or 05/24/25 (a total of four doses). The Mar revealed R3 began receiving cefazolin on the evening of 05/25/25. Review of R3's Infection Care Plan dated 05/21/25 and found in the EMR under the Care Plan Tab, revealed (R3) is on IV Cefazolin for</p> <p>(continued on next page)</p>

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: 315526	If continuation sheet Page 1 of 3

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>osteomyelitis. Interventions included Assess IV site (indicate location and type) for signs and symptoms of complication and provide medication and treatments as ordered. Review of R3's Administration Progress Notes dated 05/21/25 at 9:30 AM and found in the EMR under the Notes tab, revealed R3's Cefazolin was not administered as ordered at that time and indicated the reason as medication not on hand. There was nothing in the note to indicate R3's physician had been made aware her cefazolin was not available to be administered as ordered. Review of R3's Physician Consult Notes dated 05/21/25 at 9:42 PM and found in the EMR under the Notes tab, revealed This is a 73 yrs patient with ESRD on (dialysis) and (with) sacral wound who was admitted to (Hospital) on 4/22/25 with worsening sacral wound and evaluation for debridement. Patient was also found to have RUE (right upper extremity) cellulitis and CT (imaging of) RUE showed an upper arm loop graft with mild adjacent inflammatory changes and possible shrapnel in the right lateral arm. The patient was seen by plastics and vascular surgery. Patient was taken to the OR (Operating Room) on 04/28/25 for removal of the infected (dialysis access site) with wound vac placement and on 04/29/25 for I&D (incision and drainage procedure) of her sacral wound with ostectomy. Bone biopsy came back positive for acute osteomyelitis. The patient was treated with antibiotics as per ID (Infectious Disease) and planned to continue (antibiotics) until 05/30/25. There was nothing in the note to indicate the physician was aware R3's IV antibiotic had not been administered on that date due it not being available in the facility nor did it indicate any instructions related to ensuring the antibiotic was administered. Review of 3's Progress Notes dated 05/21/25 at 11:06 PM and found in the EMR under the Notes tab, revealed Patient has orders for IV therapy, I attempted to start a line twice with no success. Called IV access and order a Midline, technician will come place the line on 05/22/25. Daughter was made aware of the entire procedure. The document did not indicate R3's physician had been notified R3's antibiotic was not able to be administered. Review of R3's Progress Notes dated 05/22/25 at 4:28 PM and found in the EMR under the Notes tab, revealed unable to get midline (IV line) inserted due to needing renal clearance from MD (Medical Doctor) so IV medication was not administered during 7-3 shift; ADON (Assistant Director of Nursing) made aware. There was nothing in the note to indicate R3's physician was made aware the resident's antibiotic could not be administered during that shift. Review of R3's Progress Notes dated 05/22/25 at 10:23 PM and found in the EMR under the Notes tab, revealed APS (Advanced PICC Specialists) yet to come to place midline to patient, started PIVL (peripheral IV line) gauge #22 to left a.c. (antecubital). Awaiting from pharmacy to deliver IV ABX (antibiotics). There was nothing in the note to indicate R3's physician was made aware the resident's antibiotic could not be administered at that time. Review of R3's Progress Notes dated 05/23/25 and 05/24/25 and found in the EMR under the Notes tab revealed nothing to indicate why R3 did not receive ordered IV antibiotics or to indicate the resident's physician was made aware the antibiotics could not be administered on those dates. Review of R3's Physician Progress Notes dated 05/26/25 at 3:03 PM, at 10:23 PM, at 05/27/25 at 12:44 PM, and 05/28/25 at 4:50 PM (all found in the EMR under the Notes tab), revealed nothing to indicate the provider was aware R3 did not receive her IV cefazolin on 05/21/25 through 05/25/25 evening shift/that any doses of the resident's antibiotics were missed or what the plan was to address the issues leading to R3 missing her antibiotic doses four days in a row immediately after admission to the facility. Review of R3's Infectious Disease Physician Progress Notes dated 05/29/25 at 10:34 AM and found in the EMR under the Notes tab, revealed (R3) was initially treated with cefazolin and vanco (vancomycin.a potent antibiotic).and plan was for 6 week course of cefazolin until 05/30/25. (R3) was transferred to (facility) on 5/20/25; ID (Infectious Disease) consultation requested for abx (antibiotics) management; and Continue cefazolin until 05/30/25-extended by a few days as (R3) missed</p> <p>(continued on next page)</p>		

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