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

STATEMENT OF DEFICIENCIES       (X) PROVIDER/SUPPLIE/CLATION NUMBER:       (X) MULTIPLE CONSTRUCTION       (Y) ONALTE SUPPLIE         AND OF CORRECTION       33539       STREET ADDRESS, CITY, STATE, Z) FODE       0015/2010         NAME OF PROVIDER OR SUPPLIE       STREET ADDRESS, CITY, STATE, Z) FODE       2781 Route 9       2781 Route 9         Livingston Hills Nursing and Remote the deficiency, please contact the nursing home or the state survey vertex.       E       E         For information on the nursing home or the state survey vertex.       E       E       E         (24) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES       E       E       E         (24) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E       E				· · · · · · · · · · · · · · · · · · ·	
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 context 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)         Level of Harm - Unknown       No health deficiencies found		IDENTIFICATION NUMBER:	A. Building	COMPLETED	
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)         Level of Harm - Unknown       No health deficiencies found	NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)         Level of Harm - Unknown       No health deficiencies found	Livingston Hills Nursing and Rehabilitation Center				
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Level of Harm - Unknown	(X4) ID PREFIX TAG				
		No health deficiencies found			
Residents Affected - Unknown	Level of Harm - Unknown				
	Residents Affected - Unknown				

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

Facility ID: 335389