STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315223	A. BUILDING _____ B. WING _____	C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON REHABILITATION AND HEALTHCARE CENTER	**1059 EDINBURG ROAD HAMILTON, NJ 08690**

(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 #: NJ176793 CENSUS: 148 SAMPLE SIZE: 9 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Complaint: NJ176793	F 712	1. Resident #2s initial comprehensive	6/24/25

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

Electronically Signed | 06/20/2025

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 712	Continued From page 1 Based on interviews, medical record review, and review of pertinent facility documentation on 5/27/25 and 5/29/25, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents conducted an initial comprehensive visit with in the initial 30 day time period. The facility also failed to follow its policy titled, "Physician Visits." This deficient practice was identified for 1 of 9 residents (Resident #2). This deficient practice was evidenced by the following: Review of the Electronic Medical Record (EMR) on 5/27/25 and 5/29/25 was as follows: According to Resident #2's Admission Record (AR), the resident was admitted to the facility in [redacted], with diagnoses that included but were not limited to: [redacted]. According to the Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #2 had a Brief Interview of Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident was [redacted]. Review of Residents #2's Progress Notes (PNs) from [redacted] revealed the initial physician visit was completed on [redacted]. This was not within 30 days of admission. On 5/29/2025 the surveyor requested Physician notes for Resident #2 since arrival to the facility. [redacted] provided documents titled "HISTORY AND	F 712	physician visit was completed on 01/07/2024 and as recently as 6/11/25, no negative concerns were identified. 2. All residents have the potential to be affected by this practice. An audit was completed of all current residents to ensure that physician visits occurred within the required time frame. Any inconsistencies were addressed immediately. 3. The facilitys admission process has been updated to include a physician visit tracker that flags any upcoming 30-day deadlines for new admissions. [redacted] educated [redacted] and medical staff, on facility policy regarding the timeliness of physician visits. 4. The DON or designee will monitor all new admissions weekly for 4 weeks, following by monthly audit for 3 months to ensure a physician visit occurs in accordance with facility policy and reported to Committee for review and action. The QAPI Committee, including the NHA, DON, Medical Director, and Admissions Coordinator, will evaluate trends and determine whether additional interventions or education are needed.	

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F 712	Continued From page 2 PHYSICAL" dated [NJ Ex Order 26.4(b)(1)], the documents were signed by *U.S. FOIA (b) (6)* APN #1. During an interview on 5/29/2025 at 12:50P.M., the [U.S. FOIA (b)] explained she did not have any further documents from the physician from arrival. During an interview on 5/29/2025 at 1:53P.M., the *U.S. FOIA (b) (6)* stated "[NJ Ex Order 26. 4B1] [redacted]." The [U.S. FOIA (b)] stated *NJ Ex Order 26. 4B1* [redacted]." Review of the facility's Policy titled "Physician Visits" dated April 2013, under "Policy Interpretation and Implementation" revealed "The attending physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter." NJAC 8:39-23.2(d); 27.1(a)	F 712		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records.	F 842		6/24/25

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F 842	Continued From page 3 §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches	F 842		

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F 842	Continued From page 4 legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint: NJ176793 Based on interviews, record review, and review of other pertinent facility documentation on 05/29/2025, it was determined that the facility staff failed to a.) consistently document the care provided in the "Documentation Survey Report v2 (DSR)" b.) follow the facility's policy titled, "Point of Care (POC) Documentation." for a resident (Resident #2). This deficient practice was identified for 1 of 9 residents (Resident #2) reviewed. This deficient practice was evidenced by the following: Review of the Electronic Medical Record (EMR) was as follows: According to Resident #2's Admission Record (AR), the resident was admitted to the facility with diagnoses that included but were not limited to: [redacted].	F 842	1. Resident #2 was assessed that [redacted] was provided by licensed nursing staff. The residents continue to receive appropriate care per the plan of care. 2. All residents have the potential to be affected by incomplete or inconsistent documentation by not documenting that incontinent care was provided. A facility-wide audit was completed to ensure POC is completed for all current residents. Any inconsistencies were addressed immediately, and all charts were updated accordingly. 3. All Certified Nursing Assistants were re-educated on the facilitys policy titled "Point of Care (POC) Documentation," with emphasis on timely and complete documentation of care tasks, including incontinence care and toileting hygiene.	

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F 842	Continued From page 5 According to the Minimum Data Set (MDS), an assessment tool dated [NJ Ex Order 26.4(b)(1)], Resident #2 had a Brief Interview of Mental Status (BIMS) score of [NJ Ex] out of 15, which indicated the resident was *NJ Ex Order 26. 4B1*. Review of the facility's DSR commonly called the POC, for [NJ Ex Order 26.4] and NJ Ex Order 26.4(b)(1), revealed no documentation indicating that *NJ Ex Order 26. 4B1* was provided on the following dates and shifts: On August *NJ Ex Order 26. 4B1*, during the 7:00 A.M. to 3:00 P.M. shift, August *NJ Ex Order 26. 4B1*, during the 3:00 P.M. to 11:00 P.M. shift, and August *NJ Ex Order 26. 4B1* for the 11:00 P.M. to 7:00 A.M. shift. On September *NJ Ex Order 26. 4B1*, during the 7:00 A.M. to 3:00 P.M. shift, September *NJ Ex Order 26. 4B1* during the 3:00 P.M. to 11:00 P.M. shift, and September *NJ Ex Order 26. 4B1* for the 11:00 P.M. to 7:00 A.M. shift. A review of Resident #2's Progress Notes (PNs) from [NJ Ex Order 26.4] and [NJ Ex Order 26.4(b)(1)] [NJ Ex Order] did not reveal refusals of *NJ Ex Order 26. 4B1*. A review of Resident #2's Care Plan (CP) initiated on [NJ Ex Order 26.4(b)(1)] with a "Focus" of [*NJ Ex Order 26. 4B1*] with "*NJ Ex Order 26. 4B1*." During an interview on 5/27/2025 at 10:22 A.M., the Licensed Practical Nurse/Unit Manager	F 842	Education will be completed on orientation and part of annual competencies. 4. The Director of Nursing (DON) or designee will conduct daily audits of POC documentation prior to CNA end of shift for all residents for 5 consecutive days, followed by weekly audits for 3 weeks, and then monthly audits for 3 months. Results of the audits will be documented and reviewed during the facilitys monthly QAPI (Quality Assurance and Performance Improvement). The QAPI Committee, comprised of the NHA, DON, Infection Preventionist, and Medical Director, will oversee the effectiveness of these interventions and recommend additional actions if necessary.	

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F 842	Continued From page 6 (LPN/UM #1) stated "If a resident refuses care, it will be documented as refused on the CP and POC." During an interview on 5/27/2025 at 1:27 P.M., the LPN/UM #2 stated that "the CNA's (Certified Nursing Assistants) have to complete the POC for ADL's (Activities of daily living) every day. The CNA reports refusals to the nurse. If resident refuses care, we educate them and try to get the family involved, we would document it in the PNs and put a CP for resident resistant to care." During an interview on 5/29/2025 at 1:20 P.M., the [redacted] explained NJ Ex Order 26. 4B1 is documented in the POC daily for every shift. The [redacted] stated "if it is not documented then the care wasn't provided. The blank spaces mean care was not provided. If the resident refuses, I'll tell the nurse and the manager." "There should be no blanks." During an interview on 05/29/2025 at 01:53 P.M., with the U.S. FOIA (b) (6) [redacted], the [redacted] stated, "the CNAs are supposed to document for ADL's and the expectation is that they document on the POC. Blanks mean the [redacted] failed to document." The [redacted] confirmed the blank spaces on Resident #2's POC from [redacted] and [redacted]. When asked by the surveyor if the facility's policy was followed, the [redacted] stated," the policy states it should be documented. No, the policy was not followed for the blanks." Review of the facility's undated policy titled "Point of Care (POC) Document", under "Policy Implementation" revealed "1. CNA will provide resident care in accordance with each resident's individualized, plan of care/Kardex which can be	F 842		

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F 842	Continued From page 7 accessed from within POC. 2. CNAs will document the resident's self-performance, and the support provided for the activities of daily living, including: c. Toileting" and "Personal hygiene" and 3. Additional CNA documentation includes: b. Bowel and bladder continence." NJAC 8:39-35.2 (g)	F 842		

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
	061111	A. BUILDING: _____ B. WING _____	C 05/29/2025

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. 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 the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ176793 Based on interviews and review of facility documents on 05/27/2025 and 5/29/2025, it was determined that the facility failed to ensure staffing ratios were met for 14 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	1. Corrective Action for Residents Found to Have Been Affected: All staffing coordinators, unit managers, and scheduling personnel were re-educated on state staffing mandates and compliance tracking by the DON on 06/20/2025. 2. Identification of Other Residents Who May Be Affected: All residents in the facility during the day shift may have been affected by insufficient CNA staffing. 3. Measures and Systemic Changes to	6/24/25

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

Electronically Signed | 06/20/25

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S 560	Continued From page 1 nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of AAS-11 staffing, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows for 05/11/2025 to 05/24/2025: On 05/11/25 the facility had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. On 05/12/25 the facility had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. On 05/13/25 the facility had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. On 05/14/25 the facility had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs.	S 560	Prevent Recurrence: Staffing Recruitment: The facility has entered a new collective bargaining agreement as of 06/01/2025 with its union to increase wages $2.00 per hour. Daily Staffing Audits: the Director of Nursing (DON) or designee will review staffing ratios daily by shift and maintain a record to ensure compliance. Recruitment Campaign: A CNA recruitment initiative was launched including sign-on bonuses, referral incentives, job fairs and outreach to local training programs including tuition sponsorship of nursing assistants which has had successful outcomes. Through the sponsorship of Nursing Assistant training programs, the has successfully recruited and retained nursing assistants who received their Certified Nursing Assistant certification. A a new recruiter started on 06/09/2025 who is actively engaging applicants through social media and on-the-spot interviews including weekends. Daily weekday meetings are held to discuss recruitment efforts. Retention Campaign: A employee survey was conducted of 95% of all staff and results were received to facilitate feedback on actionable insights that help the facility understand, predict, and improve employee satisfaction and engagement to improve staff retention. Additionally, the facility has deployed human resource software through Retain. This software plays a proactive role in keeping employees engaged, utilized, and aligned	

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S 560	Continued From page 2 On 05/15/25 the facility had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. On 05/16/25 the facility had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. On 05/17/25 The facility had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. On 05/18/25 the facility had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. On 05/19/25 the facility had 15 CNAs for 141 residents on the day shift, required at least 18 CNAs. On 05/20/25 the facility had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs. On 05/21/25 the facility had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs. On 05/22/25 the facility had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs. On 05/23/25 the facility had 16 CNAs for 145 residents on the day shift, required at least 18 CNAs. On 05/24/25 the facility had 15 CNAs for 145 residents on the day shift, required at least 18 CNAs.	S 560	with organizational goals. It minimizes turnover by addressing the root causes of attritionoverwork, disengagement, lack of growth, and misalignment between employee goals and business needs. Additionally, the facility has an active Employee of the Month program as well as team building events to foster camaraderie and employee satisfaction. 4. Monitoring of Corrective Actions to Ensure Effectiveness: QAPI Oversight: Staffing ratio compliance will be tracked as a monthly Quality Assurance Performance Improvement (QAPI) indicator and results forwarded to the facilitys QAPI committee Weekly Review: the DON will present a weekly staffing compliance summary to the Administrator for validation by 06/24/2025 for 30 days. 30-Day Audit: A 30-day audit (ending 07/24/2025) of CNA staffing ratios will be completed and submitted to the QAPI Committee for review and validation.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315223	A. Building B. Wing	6/24/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON REHABILITATION AND HEALTHCARE CENTER	1059 EDINBURG ROAD HAMILTON, NJ 08690

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 F0712 Reg. # 483.30(c)(1)-(4) LSC	Correction Completed 06/24/2025	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(h)(1)-(5) LSC	Correction Completed 06/24/2025	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	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 5/29/2025	☐ 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
061111 Y1	A. Building B. Wing Y2	6/24/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON REHABILITATION AND HEALTHCARE CENTER	1059 EDINBURG ROAD HAMILTON, NJ 08690

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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 06/24/2025	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
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	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 5/29/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			