

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 408200	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2025
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

ADVANCED SERVICES INTERNATIONAL DAY C **841 ST GEORGE AVENUE**
ROSELLE, NJ 07203

(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
M 000	Initial Comments Type of Survey: Relocation/Reduction Census: AM Session 72 Sample Size: 11 On 10/9/2025, the Department of Health conducted a Relocation/Reduction Survey at Advanced Services International Day Care at Jersey City. The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. 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 New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 435	8:43F-7.3(a) Nursing Services The director of nursing or designated alternate shall be responsible for the supervision of all nursing staff and unlicensed assistive personnel. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the Director of Nursing (DON) failed to provide competency training to a Medical Assistant (MA), who was delegated nursing tasks.	M 435		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

10/15/25

New Jersey Department of Health

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NAME OF PROVIDER OR SUPPLIER ADVANCED SERVICES INTERNATIONAL DAY C		STREET ADDRESS, CITY, STATE, ZIP CODE 841 ST GEORGE AVENUE ROSELLE, NJ 07203		
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M 435	Continued From page 1 This deficient practice was evidenced by the following: On 10/9/25 at 11:05 a.m., the surveyor interviewed a staff member who stated that she was a MA. During interview regarding the MA job duties as a MA, the MA confirmed that her job duties included performing participants' ^{NJ Ex Order 26.4(b)(1)} and vital signs which included ^{NJ Ex Order 26.4(b)(1)} checks. Additionally, the MA stated that she completed a MA certification and completed competency training with the former DON. At 11:10 a.m., the surveyor interviewed the current DON and inquired about competency training that the MA received. The DON stated she did not provide competency training to the MA and that the MA was hired prior to her employment. At 11:20 a.m., the surveyor reviewed the MA's personnel file which revealed that the MA was employed in ^{NJ Ex Order 26.4(b)(1)} and had certificate in Medical Assisting Program dated ^{NJ Ex Order 26.4(b)(1)} in the employee's personnel file that the MA had received staff competency training to confirm that the MA demonstrated the knowledge and skills to accurately and safely perform the delegated tasks. At 11:45 a.m., the surveyor interviewed the Alternated Administrator (AA) and inquired about the MA's competency training and the AA stated that the MA completed the competency training with the former DON.	M 435		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 408200	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 10/17/2025
NAME OF FACILITY ADVANCED SERVICES INTERNATIONAL DAY CARE PLUS	STREET ADDRESS, CITY, STATE, ZIP CODE 841 ST GEORGE AVENUE ROSELLE, NJ 07203	

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 M0435	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:43F-7.3(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/10/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 10/9/2025		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			