

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315455	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER AVANT REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1314 BRUNSWICK AVENUE , TRENTON, New Jersey, 08638	
(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
F0000	INITIAL COMMENTS A Recertification Survey was conducted by Healthcare Management Solutions, LLC on behalf of New Jersey Department of Health (NJDOH). Survey Dates: 08/25/2025 through 08/28/2025 Survey Census: 145 Sample Size: 33 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 RECERTIFICATION VISIT.	F0000		09/15/2025
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure a residents who NJ Exec Order 26.4b1 medication was assessed for NJ Exec Order 26.4b1 had a physician's order for NJ Exec Order 26.4b1 and ensure the interdisciplinary care planning team was involved in the decision for the resident to NJ Exec Order 26.4b1 for one of one residents (Resident (R) 40) reviewed in the sample of 33 residents. As a result of this deficient practice the residents had the potential for harm by NJ Exec Order 26.4b1 without the knowledge of the physician or nursing staff. Findings include:	F0554	F0554 SS-D Resident Self-Admin Meds – Clinically Approp 1. Corrective Action: The medication was removed immediately from bedside, and the resident and family were educated on the process for NJ Exec Order 26.4b1 of medications. There was NJ Exec Order 26.4b1 to the resident as she had not taken any of the medication. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: Director of Nursing will educate nursing staff on the medication self-administration policy. The unit manager or designee will do visual room	09/18/2025

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 reverse for further 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
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F0554 SS = D	<p>Continued from page 1</p> <p>Review of the facility's policy titled "Administering Medications" revised 04/19 revealed, "Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely."</p> <p>Review of R40's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed an admission date of [redacted] and a readmission on [redacted] with medical diagnoses that included NJ Exec Order 26.4b1.</p> <p>Review of R40's quarterly "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of [redacted] revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] indicating R40 was NJ Exec Order 26.4b1.</p> <p>Observation on 08/25/25 at 11:09 AM, in R40's room on the bedside table were [redacted] of [redacted] one almost empty, the second [redacted] about half full.</p> <p>During an interview on 08/25/25 at 11:09 AM, R40 confirmed using the [redacted] on [redacted] when they [redacted] R40 confirmed the [redacted] had been brought by U.S. FOIA (b)(6).</p> <p>Review of R40's "Physician orders" under the "Orders" tab in the EMR lacked an order for the [redacted].</p> <p>Review of R40's "Progress Notes" under the "Prog Note" tab in the EMR lacked documentation of interdisciplinary meeting concerning NJ Exec Order 26.4b1 of medications.</p> <p>Review of the "Assessments" tab in the EMR lacked an assessment for R40's NJ Exec Order 26.4b1 of medications.</p> <p>Review of R40's Care Plan under the "Care Plan" tab in the EMR lacked documentation that R40 had been assessed</p>	F0554	<p>Continued from page 1</p> <p>inspections weekly to assure that there are no medications at the bedside x 4 weeks and then monthly x 3 months or until substantial compliance is reached.</p> <p>4.How Will These Actions Be Measured:</p> <p>The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 4 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held in October 2025.</p>	

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F0554 SS = D	Continued from page 2 for NJ Exec Order 26.4b1 of medications. During an interview on 08/28/25 at 11:07AM, Registered Nurse (RN) 2 confirmed the NJ Exec Order 26.4b1 on R40's bedside table should not be there and that they were brought in by the NJ Exec Order 26.4b1 . During an interview on 08/28/25 at 11:09 AM, the Unit Manager/Licensed Practical Nurse (LPN) 2 confirmed that R40 had not been evaluated for NJ Exec Order 26.4b1 and there was no physician's order for NJ Exec Order 26.4b1 . During an interview on 08/28/25 at 1:33 PM, the U.S. FOIA (b)(6) confirmed residents' medications were not supposed to be left at the bedside unless they were assessed for NJ Exec Order 26.4b1 of medications and there was a physician's order for the medication. NJAC 8:39-29.2(c)6	F0554		
F0568 SS = D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is NOT MET as evidenced by: Based on document review, interview, and facility policy review, the facility failed to provide written quarterly statements within 30 days of the end of the quarter to residents and/or resident representatives to inform them of the residents' balance in their personal funds accounts. This failure had the potential to affect 10 residents (R)64, R153, R104, R83, R85, R96,	F0568	F0568 SS-D Accounting and Records of Personal Funds 1. Corrective Action: All residents were provided with their written quarterly statements on 8/29/2025. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: Administrator provided education to the U.S. FOIA (b)(6) on the policy of the quarterly statements. Administrator and or designee will do quarterly audits of 10 patients per quarter for the next 2 quarters to assure that residents have been provided with a written quarterly statement within 30 days of the end of the quarter to inform them of the account balance. 4. How Will These Actions Be Measured:	09/18/2025

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F0568 SS = D	<p>Continued from page 3 R93, R29, R94, and R61) of 55 residents who had a personal funds account in the NJ Exec Order 26.4b1 to be uninformed of the balance in their account.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, "Accounting and Records of Resident Funds" dated April 2021 revealed, "Policy Statement: Our facility maintains accounting records of resident funds on deposit with the facility. Policy Interpretation and Implementation: 1. The business office maintains a record of all financial transactions involving the resident's personal funds on deposit with the facility... 5. Individual accounting records are made available to the resident through quarterly statements and upon request. Quarterly statements include the following information: a. The resident's balance at the beginning and end of the statement period; b. The total deposits and withdrawals by the resident for the quarter; c. Interest earned on the resident's funds; ..."</p> <p>Review of the facility's "Quarterly Statement for the period of NJ Exec Order 26.4b1 signature sheet)" revealed 10 residents (R) of 55 residents as having not been provided a copy of their quarterly statements. Quarterly statements for the period of NJ Exec Order 26.4b1 provided to the remaining 45 residents.</p> <p>During an interview on 08/28/25 at 3:45 PM, the U.S. FOIA (b)(6) stated, " The residents sign after receiving their quarterly statements. Based on the signature sheet for the second quarter, if there is no signature on the sheet then the statement was not provided to the resident and there is no record of the statement being given to the resident representative."</p> <p>NJAC 8:39-4.1(a)</p>	F0568	<p>Continued from page 3 The results of the quarterly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held in October 2025.</p>	
F0578 SS = D	<p>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir</p> <p>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</p> <p>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services</p>	F0578	<p>F0578 SS-D Request/Refuse/Dscntnue Trmnt; Formlte Adv Dir</p> <p>1. Corrective Action:</p> <p>R15 immediately had their NJ Ex Order 26, 4B1 placed in the paper chart as well as an order was written, and NJ Exec Order 26.4b1 was placed under the Profile tab.</p> <p>2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency:</p>	09/18/2025

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F0578 SS = D	<p>Continued from page 4 deemed medically unnecessary or inappropriate.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, record review, and policy review the facility failed to ensure the [redacted] was in easy access for one of one resident (Resident (R)15) reviewed for [redacted] information prominently displayed in the medical record in the sample of 33 residents. As a result of this deficient practice the residents had the potential for receiving [redacted] when potentially against the wishes of the residents.</p> <p>Findings include:</p> <p>Review of R15's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed an admission date of [redacted] and readmission on [redacted] with medical diagnosis that included end [redacted].</p>	F0578	<p>Continued from page 4 All residents have the potential to be affected by this deficient practice.</p> <p>3. Measures Put into Place:</p> <p>Director of Nursing will provide education to the nursing staff that all Advanced Directives must have an order and must be placed in the Profile tab in [redacted]</p> <p>Social worker and or designee will do weekly audits for 3 weeks and monthly audits x 3 months or until substantial compliance is reached to ensure that all residents have advanced directive orders and are noted in the Profile tab.</p> <p>4. How Will These Actions Be Measured:</p> <p>The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held in October 2025.</p>	

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F0578 SS = D	<p>Continued from page 5</p> <p>Review of R15's quarterly "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of [REDACTED] revealed a "Brief Interview for Mental Status (BIMS)" score of [REDACTED] indicating R15 was U.S. FOIA (b)(6).</p> <p>Review of R15's "Physician orders" under the "Orders" tab in the EMR lacked an order for [REDACTED].</p> <p>Review of R15's header in [REDACTED] next to the heading for [REDACTED] blank. Review of the "Admission Record" under the "Profile" tab in the EMR lacked documentation of [REDACTED].</p> <p>Review of R15's [REDACTED] provided by the facility, indicated R15 requested a [REDACTED] dated [REDACTED].</p> <p>Review of R15's "Care Plan" under the "Care Plan" tab in the EMR revealed a focus for [REDACTED] Status: [REDACTED] Date Initiated: [REDACTED], with intervention to ensure Resident has an order from Attending regarding [REDACTED] Date Initiated: [REDACTED].</p> <p>During an interview on 08/27/35 at 2:53AM, Unit Manager/Licensed Practical Nurse (LPN)2 explained when checking for the [REDACTED] of a resident, especially in an emergent situation, looked at the header in [REDACTED] in the computer, to verify if a resident was a [REDACTED] to know what action to take if a [REDACTED]. If the [REDACTED] was blank, the Unit Manager/LPN2 would check the hard chart for a Physician Orders for [REDACTED] form. Unit Manager/LPN2 confirmed the information was also communicated during the shift report.</p> <p>During an interview on 08/28/2025 at 11:25 AM, Unit Manager/LPN2 confirmed the header in [REDACTED] should have the [REDACTED]. The Unit Manager/LPN2 confirmed [REDACTED] was missing a physician's order for [REDACTED] and the header in PCC was blank. During an interview on 08/28/25 at 1:38PM, the U.S. FOIA (b)(6) confirmed the [REDACTED] should be prominently displayed on the EMR in the PCC header for quick</p>	F0578		

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F0578 SS = D	Continued from page 6 reference for staff, as needed. Review of the facility's policy titled "Advanced Directives" revised 12/16 revealed, "Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. ... The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive." NJAC 8:39-4.1(a) NJAC 8:39-9.6	F0578		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.	F0641	F641 SS-D Accuracy of Assessments 1. Corrective Action: On <u> </u> NJ Exec Order 26.4b1 , Resident #4 MDS assessment was reviewed and corrected, by the U.S. FOIA (b)(6) to reflect the correct medications. On <u> </u> NJ Exec Order 26.4b1 , Resident #138 MDS Assessment was reviewed and corrected, by the U.S. FOIA (b)(6) to reflect that this resident did not have an NJ Exec Order 26.4b1 in place. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: The MDS Coordinator will audit 5 MDS per week to assure MDS assessments were coded accurately. 4. How Will These Actions Be Measured: The results of the monthly MDS audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on October 2025.	09/15/2025

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F0641 SS = D	<p>Continued from page 7</p> <p>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to accurately code the "Minimum Data Set (MDS)" assessment related to medications for one of 33 sampled residents (Resident (R)4), and a [REDACTED] for one of one resident (R138) This deficient practice increased the potential for missed opportunities of care or services.</p> <p>Findings include:</p> <p>1. Review of R4's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab indicated an admission date of [REDACTED] and diagnoses of [REDACTED].</p> <p>Review of R4's quarterly "MDS" with an Assessment Reference Date (ARD) of [REDACTED] and located in the EMR under the "MDS" tab revealed that R4 was coded that [REDACTED] received an [REDACTED] medication.</p> <p>Review of R4's [REDACTED] "physician orders" revealed R4 had a current order for [REDACTED]. R4 does not have an order for an [REDACTED] medication.</p> <p>2. Review of R138's "Admission Record" located in the EMR under the "Profile" tab indicated an admission date of [REDACTED] and diagnoses of [REDACTED].</p> <p>Review of R138's admission "MDS" with an ARD of [REDACTED] and located in the EMR under the "MDS" tab revealed that R138 was coded as having an [REDACTED] in place.</p> <p>During an interview on 08/26/25 at 1:30 PM, R138 stated [REDACTED] did not have a [REDACTED] at present, or at the time of admission. R138 stated [REDACTED] was able to [REDACTED] with the use of [REDACTED] to the bathroom or [REDACTED] used [REDACTED].</p>	F0641		

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F0641 SS = D	Continued from page 8 During an interview on 08/27/25 at 4:45 PM, the [U.S. FOIA (b)(6)] stated that R138 did not have an NJ Exec Order 26.4b1 at the time of admission. The [U.S. FOIA (b)(6)] confirmed she "...misread..." hospital documentation and thought R138 had a NJ Exec Order 26.4b1 During the same interview on 08/27/25, the [U.S. FOIA (b)(6)] confirmed that R4 did not receive an NJ Exec Order 26.4b1. The [U.S. FOIA (b)(6)] stated Licensed Practical Nurse (LPN) 1 had completed R4's MDS. The [U.S. FOIA (b)(6)] further stated the facility follows the "RAI Manual" for guidance and coding and does not have a specific policy related to MDS. NJAC 8:39-33.2(d)	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the	F0656	F0656 SS-D Develop/Implement Comprehensive Care Plan 1. Corrective Action: R7 care plan was updated immediately to reflect that the resident [NJ Exec Order 26.4b1] with appropriate interventions in place. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: Director of Nursing will provide education to nursing staff that all residents that smoke should have an appropriate smoking care plan in place. Director of Nursing and or designee will do weekly audits for 3 weeks and monthly audits x 3 months or until substantial compliance is reached to assure that all residents have appropriate smoking care plan in place. 4. How Will These Actions Be Measured: The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of	09/18/2025

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NAME OF PROVIDER OR SUPPLIER AVANT REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1314 BRUNSWICK AVENUE , TRENTON, New Jersey, 08638	
(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
F0656 SS = D	<p>Continued from page 9 resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, record review, and policy review, the facility failed to ensure a resident assessed as a [redacted] had a care plan for [redacted] for one of six residents (Resident (R)7) evaluated for safety when [redacted]. As a result of this deficient practice the residents had the potential for harm while [redacted].</p> <p>Findings include:</p> <p>Review of R7's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed an admission date of [redacted] and readmitted on [redacted] with medical diagnoses that included [redacted].</p> <p>Review of R7's admission "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of [redacted] revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted], indicating R7 was [redacted].</p> <p>During an interview on 08/25/2025 at 12:00 PM, R7 confirmed [redacted] and went out on [redacted] a couple times a day.</p> <p>Review of R7's "Nursing Admission/Readmission" form under the "Assessments" tab in the EMR dated [redacted]</p>	F0656	Continued from page 9 these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held in October 2025.	

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F0656 SS = D	<p>Continued from page 10 documented R7 [redacted] NJ Ex Order 26, 4B1</p> <p>Review of R7's [redacted] "Safety Evaluation" under the "Assessments" tab in the EMR dated [redacted] documented R7's use of [redacted] and safety questions for [redacted] NJ Exec Order 26.4b1 .</p> <p>Review of R7's "Care Plan" under the "Care Plan" tab in the EMR lacked focus and interventions for [redacted] NJ Exec Order 26</p> <p>During an interview on 08/27/25 at 11:44AM, Licensed Practical Nurse (LPN)4 confirmed R7 [redacted] NJ Ex Order 26, 4B1 and there was no [redacted] NJ Exec Order 26 focus or interventions for [redacted] NJ Exec Order 26 in R7's care plan and there should be a care plan.</p> <p>During an interview on 08/28/25 at 2:53PM, Behavioral Aide (BA)1 confirmed being the monitor for the residents who [redacted] NJ Exec Order 26 and confirmed R7 came to the [redacted] NJ Exec Order 26 area three to four times a day to [redacted] NJ Exec Order 26</p> <p>During an interview on 08/28/25 at 11:30AM, the Unit Manager/Licensed Practical Nurse (LPN) 2 confirmed R7 [redacted] NJ Ex Order 26 and verified the care plan did not have a focus for [redacted] NJ Exec Order 26 and should have one.</p> <p>During an interview on 08/28/25 at 1:38PM, the [redacted] U.S. FOIA (b)(6)) confirmed that all residents who [redacted] NJ Exec Order 26 need to have a care plan for [redacted] NJ Exec Order 26 in place.</p> <p>Review of the facility's policy titled "Care Plans, Comprehensive Person-Centered" revised 03/22 revealed, "The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment."</p> <p>Review of the facility's policy titled "Smoking Policy – Residents" revised 07/17 revealed, "Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues."</p> <p>NJAC 8:39-11.2(e) NJAC 8:39-27.1(a)</p>	F0656		

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F0656 F0695 SS = D	<p>Respiratory/Tracheostomy Care and Suctioning</p> <p>CFR(s): 483.25(i)</p> <p>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.</p> <p>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, record review, and review of the facility's policy, the facility failed to clean [redacted] equipment for one of one resident (Resident (R)56) reviewed for [redacted] in the sample of 33 residents. The failure to maintain a clean [redacted] had the potential to increase the risk of [redacted] for the resident.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, "Oxygen Administration" dated October 2010 revealed the policy failed to address the need for routine cleaning and/or maintenance of [redacted], including the need to maintain a clean filter.</p> <p>Review of R56's undated "Admission Record" located in R56's electronic medical record (EMR) under the "Profile" tab revealed R56 was admitted to the facility on [redacted], with diagnoses which included [redacted].</p> <p>Review of R56's "Physician Order" dated [redacted] located in the EMR under the "Orders" tab revealed, [redacted] continuously every shift. [redacted] filter weekly every shift every Saturday."</p> <p>Observation on 08/25/25 at 4:34 PM and 08/28/25 at 1:45PM, R56's [redacted] was dirty and coated with dirt and dust.</p> <p>During observation and interview on 08/28/25 at 2:30</p>	F0656 F0695	<p>F0695 SS-D Respiratory/Tracheostomy Care and Suctioning</p> <p>1. Corrective Action:</p> <p>R56 had their [redacted] cleaned immediately.</p> <p>All residents with Oxygen concentrators had their filters cleaned immediately.</p> <p>2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency:</p> <p>All residents who have respiratory equipment have the potential to be affected by this deficient practice.</p> <p>3. Measures Put into Place:</p> <p>Admin or designee will educate maintenance on the existing policy, process and frequency for cleaning and maintaining respiratory equipment.</p> <p>Maintenance will do weekly audits of 10 patients with Oxygen concentrators for 3 weeks and monthly audits x 3 months or until substantial compliance is reached to ensure that all Oxygen concentrators have clean filters.</p> <p>4. How Will These Actions Be Measured:</p> <p>The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held in October 2025.</p>	09/18/2025

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F0695 SS = D	Continued from page 12 PM, the U.S. FOIA (b)(6) confirmed R56's NJ Exec Order 26.4b1 filter to be dirty and coated with dirt and dust. The U.S. FOIA (b) stated, "The filter should be cleaned regularly. A dirty filter can increase the risk of infections for the resident." NJAC 8:39-27.1(a)	F0695		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure the care of a NJ Ex Order 26 resident with a NJ Ex Order 26 was checked for the patency daily, and document in the medical record for one of five residents (Resident (R)15) reviewed for NJ Ex Order 26 care. As a result of this deficient practice the residents had the potential for clotting of the access point for NJ Ex Order 26 treatments. Findings include: Review of R15's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed an admission date of NJ Ex Order 26 and readmission on NJ Ex Order 26 with medical diagnosis that included NJ Ex Order 26. Review of R15's quarterly "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of NJ Ex Order 26 revealed a "Brief Interview for Mental Status (BIMS)" score of NJ Ex Order 26 indicating R15 was NJ Exec Order 26.4b1. Observation on 08/25/25 at 1:53PM, R15 held out NJ Ex Order 26.4b1 treatment center NJ Exec Order 26.4b1. Review of R15's "Care Plan" under the "Care Plan" tab in the EMR revealed the focus "Resident has NJ Ex Order 26.4b1	F0698	F0698 SS-D Dialysis 09/18/2025	
			1. Corrective Action: R15 immediately had an order placed to check for NJ Ex Order 26 every shift and to monitor site for signs and symptoms of NJ Ex Order 26 and or signs and symptoms of NJ Ex Order 26, 4B1 An immediate audit was completed to assure that all residents who receive dialysis have an order to check for thrill and bruit every shift and monitor dialysis access sites Q shift for signs and symptoms of bleeding and or signs and symptoms of infection. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: All residents who receive dialysis have the potential to be affected by this deficient practice. 3. Measures Put into Place: Nurses will be educated on assuring that all residents that receive dialysis have an order to check for thrill and bruit every shift and monitor site for bleeding or signs and symptoms of infection. 4. How Will These Actions Be Measured: Director of Nursing and or designee will do weekly audits of 5 patients who receive dialysis to assure that there is an order to check for thrill and bruit every shift and monitor site for bleeding or signs and symptoms of infection Q shift for 3 weeks and monthly audits x 3 months or until substantial compliance is achieved. The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and	

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F0698 SS = D	<p>Continued from page 13</p> <p>NJ Exec Order 26.4b1 [redacted] Date Initiated: NJ Exec Order 26.4b1 with an intervention Check for NJ Exec Order 26.4b1 every shift and document in Medication Administration Record (MAR). NJ Ex 4 of the NJ Exec Order 26.4b1 [redacted]. Date Initiated: NJ Exec Order 26.4b1.</p> <p>Review of R15's "MAR" and "Treatment Administration Record (TAR)" for U.S. FOIA (b)(6) lacked documentation that R15's [redacted] was checked for NJ Exec Order 26.4b1 through the NJ Exec Order 26.4b1. Review of the "TAR" revealed, document NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 [redacted] every shift, notify U.S. FOIA (b)(6) [redacted] of changes every shift -Start Date- NJ Exec Order 26.4b1.</p> <p>During an interview on 08/27/25 at 11:23AM, the Unit Manager/Licensed Practical Nurse (LPN) 2 confirmed that the NJ Exec Order 26.4b1 resident with an NJ Ex 4 should be checked and documented every shift and that R15 did not have an order in place to document the NJ Exec Order 26.4b1. There should be an order to document. The NJ Ex 4 was being checked for NJ Exec Order 26.4b1 every shift.</p> <p>During an interview on 08/27/25 at 11:32AM, LPN4 stated that R15's NJ Ex 4 was checked when resident returned from U.S. FOIA (b)(6) treatment and documented on the form. LPN4 stated the NJ Ex 4 should be checked more often, however, there was no place on the MAR or TAR to document the NJ Exec Order 26.4b1. LPN4 confirmed there was not a physician order to check the NJ Exec Order 26.4b1.</p> <p>During an interview on 08/28/25 at 1:27PM, the U.S. FOIA (b)(6) [redacted] confirmed there should be documentation on any NJ Exec Order 26.4b1 resident receiving treatments using NJ Ex 4 to check for the NJ Exec Order 26.4b1 every shift and document in the EMR and not just checking when resident returned from NJ Exec Order 26.4b1 treatment.</p> <p>Review of the facility's policy titled "Hemodialysis Access Care" revised 09/10 revealed, "To prevent infection and/or clotting: ... Check the patency of the site at regular intervals. Palpate the site to feel the "thrill," or use a stethoscope to hear the "whoosh" or "bruit" of blood flow through the access."</p> <p>NJAC 8:39-27.1(a)</p>	F0698	Continued from page 13 reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held in October 2025.	
F0732	Posted Nurse Staffing Information	F0732	F0732 SS-D Posted Nurse staffing Information	09/18/2025

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F0732 SS = D	<p>Continued from page 14</p> <p>CFR(s): 483.35(i)(1)-(4)</p> <p>§483.35(i) Nurse Staffing Information.</p> <p>§483.35(i)(1) Data requirements. The facility must post the following information on a daily basis:</p> <p>(i) Facility name.</p> <p>(ii) The current date.</p> <p>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <p>(A) Registered nurses.</p> <p>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).</p> <p>(C) Certified nurse aides.</p> <p>(iv) Resident census.</p> <p>§483.35(i)(2) Posting requirements.</p> <p>(i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift.</p> <p>(ii) Data must be posted as follows:</p> <p>(A) Clear and readable format.</p> <p>(B) In a prominent place readily accessible to residents, staff, and visitors.</p> <p>§483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p>	F0732	<p>Continued from page 14</p> <p>1. Corrective Action:</p> <p>The daily nursing staffing information was immediately repositioned and posted in a manner that residents and visitors in wheelchairs and with visual deficits have access to the information.</p> <p>The US FOIA (b)(6) was educated that the nursing staffing information must be posted in a manner that residents and visitors in wheelchairs and with visual deficits have access to the information.</p> <p>2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency:</p> <p>All residents and visitors have the potential to be affected by this deficient practice.</p> <p>3. Measures Put into Place:</p> <p>Admin and or designee will do weekly audits of the posted nursing staffing information to assure that it is posted in a manner that residents and visitors in wheelchairs and with visual deficits have access to the information x 3 weeks and monthly audits x 3 months or until substantial compliance is achieved.</p> <p>4. How Will These Actions Be Measured:</p> <p>The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held in October 2025.</p>	

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F0732 SS = D	<p>Continued from page 15</p> <p>Based on observation, interviews, and review of facility policy, the facility failed to ensure the daily nurse staffing information was posted in a manner that residents and visitors had access to the information. This deficient practice has the potential to affect all residents and visitors.</p> <p>Findings include:</p> <p>Upon entrance to the facility on 08/25/25 at 9:00 AM, the daily nurse staffing information was observed in a glassed bulletin board, behind the main reception desk at the upper left corner, approximately six feet high. The posting was current for the day, all three shifts, however, was not readable, or accessible, for residents in a wheelchair or with vision problems.</p> <p>Observations on the subsequent survey days of 08/26/25 at 3:30 PM, 08/27/25 at 1:00 PM and 08/28/25 at 11:15 AM revealed the daily nurse staffing information was in a glassed bulletin board, behind the main reception desk at the upper left corner, approximately six feet high. The posting was current for the day, all three shifts, however, would not be readable, or accessible, for residents in a wheelchair or with vision problems.</p> <p>During an interview on 08/28/25 at 12:00 PM the J.S. FOIA (b)(6) stated the daily nurse staff information has "...always been posted in the glass bulletin board..." She also stated that residents do not come behind the receptionist desk and that the nurse staffing posting was not accessible, or visible, to residents in a wheelchair.</p> <p>During an interview on 08/28/25 at 12:15 PM, the J.S. FOIA (b)(6) stated that the daily nurse staffing information was not posted in any other location other than behind the reception desk.</p> <p>NJAC 8:39-41.2</p>	F0732		
F0812 SS = F	<p>Food Procurement,Store/Prepare/Serve-Sanitary</p> <p>CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements.</p> <p>The facility must -</p>	F0812	<p>F812</p> <p>Plan of Correction (POC) – Wet Nesting</p> <p>1.Issue Identified:</p> <p>During a recent audit/observation, wet nesting was</p>	09/15/2025

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F0812 SS = F	<p>Continued from page 16</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure kitchen staff thoroughly cleaned and air-dried pots and pans prior to storage. This failure had the potential to increase the risk of foodborne illness and had the potential to affect 143 of 145 residents who received dietary services.</p> <p>Findings include:</p> <p>Review of the facility's undated policy titled, "Pot Washing" revealed, "Policy: Kitchen will wash, rinse, and sanitize, all pots, pans, and cook ware and small wares following each meal. Procedure... 10. Air dry all clean and sanitized pots and wares. Do not wipe dry."</p> <p>Review of the facility's undated policy titled, "Wet Nesting" dated Oct.22 revealed, "Policy: When ware washing plates, cups, bowls, eating utensils, kitchen utensils, cooking ware, and equipment they must be air dried completely before being placed into storage for use. Procedure... Place items on drying rack and allow them to air-dry. Do not stack. Do not wipe dry any items; they must be allowed to air dry. Once items have dried completely, they can be properly stored... All coffee pots and air pots must be allowed to dry inverted (upside down) so that there is no standing water left inside."</p>	F0812	<p>Continued from page 16 identified—dishes, cups, and/or pans were stacked while still wet, creating a risk for bacterial growth and non-compliance with sanitation standards.</p> <p>2. Corrective Action:</p> <p>All stacked items were immediately unstacked, re-washed, sanitized, and properly air-dried before being stored.</p> <p>Staff directly involved were counseled and re-educated on proper drying and storage procedures.</p> <p>3. Systemic Changes / Preventive Measures:</p> <p>In-service training provided to all dietary staff on proper dishwashing and storage procedures on August 27th, 2025, emphasizing the prevention of wet nesting.</p> <p>Visual "No Wet Nesting" reminder signage posted at dishwashing and storage areas.</p> <p>Updated Closing Checklist to include verification that all stored dishware, utensils, and pans are completely dry before stacking.</p> <p>4. Monitoring / Quality Assurance:</p> <p>Food Service Director and/or Supervisor will conduct checks of dish storage areas to ensure compliance daily x 4 weeks, followed by weekly x 3 months.</p> <p>Results will be documented and reviewed weekly. Any non-compliance will result in immediate corrective retraining.</p> <p>Findings will be reported during monthly QA meetings to track progress and ensure ongoing compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315455	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER AVANT REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1314 BRUNSWICK AVENUE , TRENTON, New Jersey, 08638	
(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
F0812 SS = F	Continued from page 17 During an observation and interview on 08/25/25 at 10:20 AM, the U.S. FOIA (b)(6) confirmed two pans, 12 inches by 24 inches by 4 inches deep; two pans 12 inches by 24 inches by 3 inches deep; one 12 inches by 24 inches; two pans, 10 inches by 12 inches by 4 inches had been cleaned and stacked for use, were still wet when they were stacked. The pans were found to have been stacked wet and not allowed to properly air dry prior to being stacked. Interview at this time, the U.S. FOIA (b)(6) stated, "They should be dry. They shouldn't be wet. They weren't dry before they were stacked. When they are put away wet, it increases the risk of contamination." NJAC 8:39-17.2(g)	F0812		

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 476002	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER AVANT REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1314 BRUNSWICK AVENUE , TRENTON, New Jersey, 08638	
(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
S0560	<p>Continued from page 1</p> <p>One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and</p> <p>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.</p> <p>For the 2 weeks of staffing, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows:</p> <p>-08/10/25 had 13 CNAs for 141 residents on the day shift, required at least 18 CNAs.</p> <p>-08/23/25 had 17 CNAs for 141 residents on the day shift, required at least 18 CNAs.</p>	S0560	<p>Continued from page 1</p> <p>identifying opportunities for process improvements The audit results will be reported to the Quality Assurance and Performance Improvement committee on a monthly basis X 3 months for review and further recommendations.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315455	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/12/2025
NAME OF PROVIDER OR SUPPLIER AVANT REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1314 BRUNSWICK AVENUE , TRENTON, New Jersey, 08638	
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F0000	<p>INITIAL COMMENTS</p> <p>An offsite/desk review of the facility's Plan of Correction was conducted on 12/12/2025 in relation to the 8/25/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p>	F0000		12/22/2025

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 reverse for further 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
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New Jersey State Department of Health

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 12/12/2025 in relation to the 8/25/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		12/22/2025

Office of Primary Care and Health Systems Management

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315455	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025
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K0000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 08/26/25 and the facility was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.</p> <p>Avant Rehabilitation and Care Center is a three-story building built in the 1980's. It is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator powers approximately 50% of the building per the U.S. FOIA (b)(6) The current occupied beds are 145 of 149.</p>	K0000		09/15/2025
K0222 SS = F	<p>Egress Doors</p> <p>CFR(s): NFPA 101</p> <p>Egress Doors</p> <p>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:</p> <p>CLINICAL NEEDS OR SECURITY THREAT LOCKING</p> <p>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p>SPECIAL NEEDS LOCKING ARRANGEMENTS</p>	K0222	<p>K0222 EGRESS DOORS</p> <p>1. Corrective Action:</p> <p>Egress door by room [REDACTED] was repaired immediately and all other doors were checked to ensure they were working.</p> <p>Proper signage was placed on all delayed egress doors.</p> <p>2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency:</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>3. Measures Put into Place:</p> <p>Administrator educated the maintenance department on egress door and signage.</p> <p>Egress door by room [REDACTED] was repaired immediately and</p>	09/18/2025

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 reverse for further 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.

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K0222 SS = F	<p>Continued from page 1 Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p>DELAYED-EGRESS LOCKING ARRANGEMENTS</p> <p>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</p> <p>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</p> <p>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations and interview, it was determined that the facility 1.) failed to ensure one of four stairway exit fire doors equipped with delayed egress hardware opened when pushed upon; and 2.) failed to ensure four of four stairway exit fire doors were equipped with signage of "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.1.10.1 and 7.2.1.6.1.1 (4). This deficient practice had the</p>	K0222	<p>Continued from page 1 all other doors were checked to ensure they were working.</p> <p>Proper signage was placed on all delayed egress doors.</p> <p>4.How Will These Actions Be Measured:</p> <p>Door inspections will be done quarterly x3 by the Director of maintenance.</p> <p>The results of the audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months Based on the results of these audits; a decision will be made regarding the need for continued submission and reporting.</p>	

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K0222 SS = F	<p>Continued from page 2 potential to affect all 145 residents and was evidenced by the following:</p> <p>An observation on 08/26/25 at 1:42 PM revealed the stairway exit access door near room [REDACTED] would not release from the magnet that held it closed for the delayed egress. The U.S. FOIA (b)(6) pushed on the door for over two minutes, and the door still would not release from its magnet.</p> <p>An observation on 08/26/25 from 12:00 PM to 3:00 PM revealed the stairway exit access doors equipped with delayed egress hardware near room [REDACTED], near room [REDACTED], near room [REDACTED], and near room [REDACTED] did not have signage which indicated the door would open in 15 seconds.</p> <p>During an interview at the time of the observations, the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) confirmed the stairway door on the second floor near room [REDACTED] would not open and confirmed the stairway fire doors on the second and third floors did not have signs reading PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS.</p> <p>NJAC 8:39-31.2(e)</p>	K0222		
K0324 SS = F	<p>Cooking Facilities</p> <p>CFR(s): NFPA 101</p> <p>Cooking Facilities</p> <p>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:</p> <ul style="list-style-type: none"> * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous</p>	K0324	<p>K0324 Cooking Facilities</p> <p>1. Corrective Action:</p> <p>Our kitchen suppression system inspections that were not up to date are currently up to date.</p> <p>2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency:</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>3. Measures Put into Place:</p> <p>Administrator educated the maintenance department on timely kitchen suppression system inspections. And that all inspections must be scheduled timely with our contracted vendor.</p> <p>4. How Will These Actions Be Measured:</p>	09/18/2025

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K0345 SS = F	Continued from page 4 determined that the facility failed to ensure the smoke detector sensitivity testing was completed on the fire alarm system every other year in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) section 14.4.4.3.2. This deficient practice had the potential to affect all 145 residents and was evidence by the following: A review of the facility's fire safety binder for 2024 and 2025 revealed smoke sensitivity testing had not been completed on the fire alarm system. During an interview on 08/26/25 at 4:30 PM, the U.S. FOIA (b)(6) confirmed the smoke detector sensitivity testing was not completed on the fire alarm system. NJAC 8:39-31.1(c), 31.2(e) NFPA 72	K0345	Continued from page 4 Administrator educated the maintenance department on timely Smoke Sensitivity inspections. 4.How Will These Actions Be Measured: Smoke Sensitivity inspections will be done every 2 years by our contracted vendor. The reports will be submitted to the administrator for review and to ensure inspections are done timely. The results of the inspections will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months, based on the results of these inspections; a decision will be made regarding the need for continued submission and reporting.	
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on document review and interview, it was	K0353	K0353 Sprinkler System - Maintenance and Testing 1.Corrective Action: Sprinkler System inspections that were not up to date are currently up to date. 2.Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: All residents have the potential to be affected by this deficient practice. 3.Measures Put into Place: Administrator educated the maintenance department on timely Sprinkler System inspections, monitoring and scheduling with our vendor. 4.How Will These Actions Be Measured: Sprinkler System inspections will be done Quarterly by our contracted vendor. The administrator or designee will ensure timely inspections are completed. The results of the inspections will be submitted to the Quality Assurance and Process Improvement Committee	09/18/2025

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K0353 SS = F	<p>Continued from page 5 determined that the facility failed to ensure the sprinkler system's control valves, water flow alarms, and tamper switches or supervisory signals were inspected and/or tested quarterly in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems (2011 Edition) section 5.1.1.2 and 5.1.1.2 Table. This deficient practice had the potential to affect all 145 residents and was evidenced by the following:</p> <p>A review of the facility's fire safety binder for 2024 and 2025 revealed the sprinkler system had an annual inspection on 08/15/24, quarterly inspection on 12/31/24, and a quarterly inspection on 05/21/25; however, there was no documented evidence a quarterly inspection was completed for the first quarter of 2025.</p> <p>]</p> <p>During an interview on 08/26/25 at 4:30 PM, the U.S. FOIA (b)(6) confirmed the sprinkler system was not tested in the first quarter of 2025. The U.S. FOIA (b)(6) U.S. FOIA (b)(6) stated that they were having an issue with the sprinkler contractor for the first part of the year.</p> <p>NJAC 8:39-31.1(c), 31.2(e)</p> <p>NFPA 13, 25</p>	K0353	<p>Continued from page 5 Meeting monthly for 3 months. Based on the results of these inspections, a decision will be made regarding the need for continued submission and reporting.</p>	
K0372 SS = F Bldg. 01	<p>Subdivision of Building Spaces - Smoke Barrie</p> <p>CFR(s): NFPA 101</p> <p>Subdivision of Building Spaces - Smoke Barrier Construction</p> <p>2012 EXISTING</p> <p>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.</p> <p>19.3.7.3, 8.6.7.1(1)</p> <p>Describe any mechanical smoke control system in REMARKS.</p> <p>This STANDARD is NOT MET as evidenced by:</p>	K0372	<p>K0372 Subdivision of Building Spaces - Smoke Barrier</p> <p>1. Corrective Action:</p> <p>All penetrations that were on the smoke barriers were repaired by the maintenance department.</p> <p>2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency:</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>3. Measures Put into Place:</p> <p>Administrator educated the maintenance department on the hazards of penetrations on smoke barriers. Maintenance will do a semi-annual sweep of the building to ensure there are no penetration of the smoke barrier.</p>	09/18/2025

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NAME OF PROVIDER OR SUPPLIER AVANT REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1314 BRUNSWICK AVENUE , TRENTON, New Jersey, 08638	
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K0372 SS = F Bldg. 01	<p>Continued from page 6</p> <p>Based on observations and interview, it was determined that the facility failed to ensure penetration in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and that smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6.2. This deficient practice had the potential to affect all 30 residents who resided on the first floor at the facility and was evidenced by the following:</p> <p>Observations on 08/26/25 from 12:00 PM until 3:00 PM of the facility's smoke barriers, revealed the NJ floor hallway between rooms NJ Exec Order 26.4b1 had four NJ Exec Order 26.4b1 wires and eight NJ Exec Order 26.4b1 (Ethernet cable commonly used for networking computers and other devices) penetrating an eight-inch by five-inch unsealed opening on both sides of the smoke barrier.</p> <p>During an interview at the time of observations, the U.S. FOIA (b)(6) confirmed the above penetration in the smoke barrier.</p> <p>NJAC 8:39-31.2(e)</p>	K0372	<p>Continued from page 6</p> <p>4.How Will These Actions Be Measured:</p> <p>Maintenance will do a semi-annual sweep of the building.</p> <p>The results of the audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315455	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER AVANT REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1314 BRUNSWICK AVENUE , TRENTON, New Jersey, 08638	
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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 08/26/25. The facility was found to be in compliance with 42 CFR 483.73	E0000		09/15/2025

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 reverse for further 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
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315455	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/22/2025
NAME OF PROVIDER OR SUPPLIER AVANT REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1314 BRUNSWICK AVENUE , TRENTON, New Jersey, 08638	
(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
K0000 Bldg. 01	<p>INITIAL COMMENTS</p> <p>An offsite/desk review of the facility's Plan of Correction was conducted on 12/22/2025 in relation to the 8/28/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.</p>	K0000		

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 reverse for further 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.

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