STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315455	A. BUILDING _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANT REHABILITATION AND CARE CENTER	**1314 BRUNSWICK AVENUE TRENTON, NJ 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
F 000	INITIAL COMMENTS COMPLAINT #: NJ176893, NJ182412, NJ182443 CENSUS: 132 SAMPLE SIZE: 9 THE FACILITY IS 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		

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

Electronically Signed | 02/25/2025

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	476002	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANT REHABILITATION AND CARE CENTER	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

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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 #: NJ176893, NJ182412, NJ182443 Based on review of facility documents on 02/13/25 and 02/14/2025, 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	S560 Mandatory Access to Care 1.Immediate Action The Administrator and Director of Nursing educated the staffing coordinator to ensure the facility maintains the required minimum direct care staff-resident ratios daily as mandated by the state of New Jersey. 2.Identification of Others All residents have the potential to be affected by any staffing shortage. 3.Systemic change The facility is constantly conducting wage	2/24/25

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

Electronically Signed | 02/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	476002	A. BUILDING: _____ B. WING _____	C 02/13/2025

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AVANT REHABILITATION AND CARE CENTER	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

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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 staffing prior to survey from 01/26/2025 to 02/08/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: On 01/26/25, the facility had 14 CNAs for 137 residents on the day shift, required at least 17 CNAs. On 01/27/25, the facility had 14 CNAs for 135 residents on the day shift, required at least 17 CNAs. On 01/28/25, the facility had 16 CNAs for 135 residents on the day shift, required at least 17 CNAs. On 01/29/25, the facility had 16 CNAs for 135 residents on the day shift, required at least 17 CNAs.	S 560	analyses and studies to stay competitive in the market. We are utilizing various resources, including our in-house recruiting team, to recruit, hire, and retain staff. Additionally, we are offering competitive sign-on and referral bonuses to attract and retain staff. Staffing agencies are being utilized to fill any vacancies in our schedules. 4. Quality monitoring The Administrator and or staffing coordinator have weekly meetings to ensure the efficiency of the systems that are in place, by reviewing upcoming schedules and 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	

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S 560	Continued From page 2 On 01/30/25, the facility had 15 CNAs for 135 residents on the day shift, required at least 17 CNAs. On 01/31/25, the facility had 15 CNAs for 137 residents on the day shift, required at least 17 CNAs. On 02/01/25, the facility had 11 CNAs for 137 residents on the day shift, required at least 17 CNAs. On 02/02/25, the facility had 12 CNAs for 137 residents on the day shift, required at least 17 CNAs. On 02/03/25, the facility had 15 CNAs for 136 residents on the day shift, required at least 17 CNAs. On 02/04/25, the facility had 16 CNAs for 135 residents on the day shift, required at least 17 CNAs. On 02/05/25, the facility had 16 CNAs for 135 residents on the day shift, required at least 17 CNAs. On 02/06/25, the facility had 16 CNAs for 135 residents on the day shift, required at least 17 CNAs. On 02/07/25, the facility had 15 CNAs for 135 residents on the day shift, required at least 17 CNAs. On 02/08/25, the facility had 15 CNAs for 134 residents on the day shift, required at least 17 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
476002 (Y1)	A. Building B. Wing (Y2)	2/26/2025 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANT REHABILITATION AND CARE CENTER	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

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 02/25/2025	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
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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	
2/13/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO