STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON REHAB AND CARE CENTER	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(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 A Complaint Survey was conducted on behalf of the New Jersey Department of Health (NJDOH). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 05/14/24 through 05/17/24 Survey Census: 119 Sample Size: 24 C#NJ 148344 C#NJ 148677 C#NJ 149694 C#NJ 150998 C#NJ 151015 C#NJ 155322 C#NJ 156138 C#NJ 157737 C#NJ 159653 C#NJ 159894 C#NJ 160209 C#NJ 160526 C#NJ 161200 C#NJ 165686 C#NJ 168838 C#NJ 169816 C#NJ 169843 C#NJ 170012 C#NJ 167538 C#NJ 170105 C#NJ 172129 C#NJ 172626 C#NJ 173221	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		7/16/24

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

Electronically Signed | 06/28/2024

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F 584	Continued From page 1 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: C#NJ 148344 C#NJ 148677 Based on observation, interview, and facility policy review, the facility failed to ensure window screens were in good repair, open windows had screens; and failed to ensure walls and floors in resident rooms were maintained in clean condition for 10 of 53 rooms. This failure created a non-homelike environment. Findings include: Observation on 05/14/24 at 3:38 PM of resident room [NJ Ex O] revealed the window screen in the	F 584	1. Resident Room #[NJ Ex O] #[NJ Ex O] #[NJ Ex O] #[NJ Ex O] #[NJ Ex O] #[NJ Ex O] #[NJ Ex O] #[NJ Ex O] windows and resident activity room Unit B3 window Will be Fixed or Replaced. Rooms #[NJ Ex O] and #[NJ Ex O] were cleaned. 2. Housekeeping will be reeducated on a proper home like environment, which includes window screens being in good repair and walls and floors maintained in clean condition. 3. An audit of 6 rooms will be conducted	

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F 584	Continued From page 2 window had a hole that extended the entire width of the window. Observation on 05/15/24 at 10:58 AM of resident room [NJ Ex O] revealed the window screen was torn all the way across the window. Observation on 05/15/25 at 2:41 PM of resident room [NJ Ex O] revealed the window screen was torn all the way across the window. Observation on 05/15/24 at 11:47 AM of resident rooms [NJ Ex On] [NJ Ex On] and [NJ Ex O] revealed the window screens were torn and had several holes. Observation on 05/15/24 at 2:14 PM of resident room [NJ Ex O] revealed the window screen [NJ Ex O] was torn all the way across the window. Observation on 05/14/24 at 11:06 AM of resident room [NJ Ex O] revealed the window did not contain a window screen. Continued observation revealed the window was opened approximately two inches. The window did not have a screen to prevent the entrance of insects. Observation on 05/15/24 at 3:39 PM of the window in the resident activity room on unit B3 was open approximately two inches. Continued observation revealed there was no screen in place to prevent the entrance of insects. Observation on 05/15/24 at 11:05 AM of resident room [NJ Ex O] revealed the wall by the door and under the window was soiled with dried, yellow-colored drips. The floor had brown dirt built up along the walls all the way around the room. Observation on 05/15/24 at 11:17 AM of resident	F 584	weekly by the Director of Maintenance or designee for room cleanliness and proper screenage. 4. The findings of the audits will be brought to the Quality Improvement Committee Monthly for 3 Months and quarterly thereafter.	

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F 584	Continued From page 3 room NJ Ex O revealed what appeared to be dirt build up on the floor along the wall in room. During an observation and interview on 05/15/24 at 2:41 PM, the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) verified the walls and floor were both soiled. The U.S. FOIA (stated it appeared as if someone waxed over the dirt on the floor along the walls. Continued observation of the above identified rooms revealed both the U.S. FOIA (and the U.S. FOIA (b) (6) verified the concerns. Review of the facility's policy titled "Environment Care" revised 05/01/23, stated the Maintenance Department would maintain the building in good repair. Review of the facility's policy titled, "Housekeeping" revised 09/01/23. The policy indicated the facility would have enough equipment and supplies required to meet the needs of the housekeeping services. NJAC 8:39-4.1(a)11, 31.4(a)	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		7/31/24

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F 609	Continued From page 4 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: C#NJ 172626 Based on observation, record review, interview, and review of the facility's policy, the facility failed to ensure an NJ Ex Order of Unknown origin was immediately reported to the State Survey Agency in accordance with the required timeframes for one of five residents (Resident (R) 20) reviewed for NJ Ex Order 26.4(b) unknown origin out of a total sample of 24. R20 was found with NJ Ex Order 26.4(and NJ Ex Order 26.4(to the NJ Ex Order 26.4(b on NJ Ex Order 26.4(b which resulted in a NJ Ex Order 26.4(b)(1) . The facility did not report the NJ Ex Order of unknown origin until NJ Ex Order 26.4(b, which was NJ Ex O days later. This failure placed the resident at risk of possible NJ Ex Order when. Findings include: Review of the facility's policy titled, "Abuse,	F 609	1.A.Residents were assessed to ensure safety and to ensure no skin injury of unknown etiology were noted. B. Staff were educated on reporting and its timeliness to state and government agencies. 2. A.Current residents will be interviewed to determine whether they have skin injury with unknown etiology B.Skin assessment completed to ensure no bruises or injuries of unknown origin exist for residents that are unable to be interviewed 3. Employees will receive a monthly education for the next 6 months and quarterly thereafter on reporting and its timeliness to the state and government agencies. 4. Education will be reviewed by the Administration or designee to ensure that	

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F 609	Continued From page 5 Neglect, Exploitation or Misappropriation-Reporting and Investigating," revised April 2021, indicated, "All reports of resident abuse (including injuries of unknown origin) ...are reported to local, state and federal agencies (as required by current regulations) ...Reporting Allegations to the Administrator and Authorities- 1. If resident ...injury of unknown source is suspected, the suspicious must be reported immediately to the administrator and to the other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility, b. The local/state ombudsman ...3. 'Immediately' is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury." During an observation and interview on 05/14/24 at 9:55 AM, R20 was observed in [NJ Ex O] room sitting in a wheelchair. Further observation revealed R20's [NJ Ex Order 26.4(b] had a [NJ Ex Order 26.4(b)(1)] on it. R20 was asked what happened and stated, "I was [NJ Ex Order 26.4(b)(1)], or [NJ Ex O] I [NJ Ex Order 26.4(b)(1)]. I [NJ Ex Order 26.4(b)(1)]. I must have [NJ Ex Order 26.4(b)(1)] because I [NJ Ex Order 26.4(b)(1)]. This was awhile back." Review of R20's undated "Face Sheet" located in the resident's electronic medical record (EMR) under the "Resident" tab indicated R20 was admitted to the facility on [NJ Ex Order 26.4(b]. Review of R20's medical diagnoses located in the resident's EMR under the "Med Diag [Diagnoses]" tab indicated diagnoses to include [NJ Ex Order 26]	F 609	staff are educated on reporting and its timeliness to state and government agencies.	

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F 609	Continued From page 6 NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). Review of R20's significant change "Minimum Data Set (MDS)" with an assessment reference date (ARD) of NJ Ex Order 26.4(b) and located in the resident's EMR under the "MDS" tab revealed the facility assessed R20 to have a "Brief Interview for Mental Status (BIMS)" score of NJ Ex out of 15 which indicated the resident was NJ Ex Order 26.4(b)(1). The MDS further indicated R20 had an NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b) to the NJ Ex Order 26.4(b)(1) and on NJ Ex Order 26.4(b) of the NJ Ex Order 26.4(b)(1). The MDS further indicated R20 required "Partial/Moderate" assistance for transfers. Review of R20's "Reportable Event Record/Report" provided by the U.S. FOIA (b) (6) indicated "Date of Event NJ Ex Order 26.4(b) at 2:00 PM. Today's date: NJ Ex Order 26.4(b). Was this a significant event? Yes. Was Significant event called in? Yes. Date: NJ Ex Order 26.4(b) at 1:55 PM. Person reporting: [name of former U.S. FOIA (b) (6) Location of Incident: NJ Ex Order 26.4(b)(1). Type of Incident: NJ Ex Order 2 Narrative: Describe the event: Resident noted with NJ Ex Order 26.4(and NJ Ex Order 26.4(to NJ Ex Order 26.4(b) on NJ Ex Order 26.4(b). When resident was asked what happened to NJ Ex Order 26.4(NJ Ex O stated that NJ Ex O must have NJ Ex Order 26.4(b)(1 during a NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b). What interventions were implemented after the incident/event? NJ Ex Order was ordered to the NJ Ex Order 26.4(b) with impression of NJ Ex Order 26.4 of the NJ Ex Order 26.4(b)(1)." Further review of the incident report revealed this incident was not reported until NJ Ex Order 26.4(b) (NJ Ex O days after it was identified).	F 609		

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F 609	Continued From page 7 Review of R20's "NJ Ex Order Results" dated NJ Ex Order 26.4(b) and located in the resident's EMR under the "Misc [Miscellaneous]" tab revealed an NJ Ex Orde was not conducted until NJ Ex Order 26.4(b) (NJ Ex Orde days after finding the resident with NJ Ex Order 26.4(and NJ Ex Order 26.4(to the NJ Ex Order 26.4(b) which revealed, "Findings: Marked NJ Ex Order 26.4(b)(1) is noted. There is a NJ Ex Order 26.4(b)(of the NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4 suspected. Impression: NJ Ex Order 26.4(of the NJ Ex Order 26.4(b)(1) ." Review of the facility's "Investigation Summary" dated NJ Ex Order 26.4(b) and provided by the facility indicated, Resident [R20] with NJ Ex Order 26.4(and NJ Ex Order 26.4(to the NJ Ex Order 26.4(b) on NJ Ex Order 26.4(b) , NJ Ex Orde done to NJ Ex Order 26.4(b) with NJ Ex Order 26.4(b)(1) of NJ Ex [redacted] ." During an interview on 05/14/24 at 1:49 PM, the U.S. FOIA (b) (6)) stated, "This was reported on NJ Ex Order 26.4(b) . Initially NJ Ex C [referring to R20] had NJ Ex Order 26.4(to the NJ Ex C on NJ Ex Order 26.4(b) . We did an NJ Ex Orde and sent NJ Ex C to the hospital on NJ Ex Order 26.4(b) . NJ Ex Or returned the same day with NJ Ex Order 26.4(b) and [the facility] reported [it] the next day." When the U.S. FOIA (was asked why the delay in reporting, NJ Ex C stated, "We were gathering all the information and as soon as we completed it, we reported it to the state. Most of the time reportables or any types of NJ Ex Order 26 of unknown origin, we complete an incident report and report within 24-48 hours." NJAC 8:39-9.4(f)	F 609		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		7/8/24

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F 761	Continued From page 8 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, the facility failed to ensure medications were locked in a secure storage area and only authorized personnel had access to the medications. Observation revealed medications delivered by the pharmacy was left at a nurses' station where residents, visitors, and unauthorized employees had access to the medications. This had the potential to cause injury to residents who would ingest them or to residents who need them in the event they are stolen due to not being supervised. This had the potential to affect the 93 residents residing on the second floor with a census of 119.	F 761	In serviced the nursing department on medication storage. Supervisor or designee will be responsible for receiving medication and ensuring its proper storage. Director of Nursing or designee will conduct weekly audits on receiving of medications and its storage. The Findings of this audit will be brought to the Quality Improvement Committee monthly for 3 months and quarterly thereafter.	

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F 761	Continued From page 9	F 761		

Findings include:

Observation on 05/16/23 at 6:05 AM of the second floor nurses' station revealed four brown paper bags of medications sitting on the nursing station within plain view and within reach of anyone standing at the nursing station. Continued observation revealed no staff around were in the line of sight of the bags of medications and Resident (R) 24 was sitting in a chair across from the nursing station.

During the continuous observation on 05/16/23, at 6:10 AM Certified Nurse Aide (CNA) 9 came behind the nursing station and sat down and began working on the computer next to the bags of medications. At 6:12 AM Licensed Practical Nurse (LPN) 6 arrived at the nurses' station. LPN6 stated the medications had arrived from the pharmacy that morning and they should have been locked up. She verified CNA9 was sitting in the nursing station and R24 was sitting in the hall directly across from the nurses' station where the medications were sitting. Three of the bags were open with easy access to any of the medications and one of the bags was stapled shut.

Observation on 05/16/24 of the bags of medications with LPN6 revealed the bags contained the following medications: Humalog insulin, a card containing 24 tablets of pantoprazole, Finasteride (one card of 24 tablets)a urinary retention medication; Amlodipine (two cards of 24 pills) a high blood pressure medication, Gabapentin (three cards of 24 tablets) an anticonvulsant, Midodrine (three cards of 24 tablets) a blood pressure medication, Torsemide (one card) a diuretic, Paliperidone (one card) a antipsychotic, singular (one card)a

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F 761	Continued From page 10 leukotriene receptor antagonists, escitalopram (one card) antidepressant, Levison (one card) a anticholinergic, Lipitor (three cards) a statin, amantadine (one card) Parkinson's medication, Prevacid (two cards) a stomach acid reducer, entacapone (three cards) a Parkinson's medication, Catapres (two cards) a high blood pressure medication, ibuprofen (one card) a pain reducer, Pepcid (one card) an acid reducer for reflux, Vitamin D (one card), Depakote (one card) an anticonvulsant, and (Keflex one card) an antibiotic. R24's quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of NJ Ex Order 26.4(b) located in the "MDS" tab of the electronic medical record (EMR) revealed the facility assessed the resident to have a "Brief Interview for Mental Status" score of NJ E out of 15 which indicated the resident was NJ Ex Order 26.4(b)(1). The "MDS" also indicated the resident was independent with NJ Ex Order 26.4(b)(1). Review of the facility's "Census" sheet dated 05/13/24 and provided by the facility revealed 93 residents resided on the second floor. Review of the facility's policy titled "Storage of Medications" revised date of 2020 stated, " ...Drugs and biologicals used in the facility are stored in locked compartments ...only persons authorized to prepare and administer the medications have access to the locked medications." NJAC 8:39-29.4(h)	F 761		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed	F 803		7/16/24

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F 803	Continued From page 11 CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: C#NJ 148344 Based on observation interview, and facility policy review, the facility failed to ensure the meal menu was followed. This failure had the potential to result in weight loss and/or continued hunger for 40 of 119 residents. Findings include:	F 803	#1 Director of Dietary Services Conducted an in service on correct portion control per diet extension and recipe. #2 Director of Dietary Services or Designee will set up a sample plate with the correct portion per diet extension and recipe 3 meals a day. #3Director of Dietary Services will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. BUILDING _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON REHAB AND CARE CENTER	2020 ROUTE 23 NORTH WAYNE, NJ 07470

(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 803	Continued From page 12 Observation and interview on 05/14/24 at 11:45 AM in the kitchen revealed Dietary Employee (DE) 1 placed the scoops/serving utensils in the food items located on the steam table. He placed a #10 scoop (3.2-ounce scoop) in the sausage paella. He was observed to serve the residents on the first three carts the 3.2 ounce serving when the menu stated a 6-ounce portion should have been given. At 11:45 AM DE1 verified he used the #10 scoop to serve the sausage paella. At 11:54 AM the scoop size was again verified with DE1 and the U.S. FOIA (b) (6)). The DE used the 3.2-ounce scoop to serve the trays on the first and second carts to the first floor, and to the residents on the first cart to the second floor. During an interview on 05/16/24 at 9:12 AM the menu for the lunch meal on 05/14/24 meal was reviewed with the U.S. FO and the U.S. FOIA (b) (6) . Review of the menu revealed the regular and chopped diets were supposed to receive six ounces of the sausage paella. The U.S. FO verified DE1 should have used a six-ounce scoop for the sausage paella. Review of the list of residents on the carts with there diets was requested. On 05/16/24 at 10:30 AM the list was provided. Review of the list revealed 26 residents on regular diets were on the first two carts to the first floor and 14 resident trays for residents on regular diets was sent to the second floor. Review of the facility's policy titled "Menu Accuracy Policy" dated 12/10/23 stated the "Facility kitchen staff will follow menu in place as provided, as approved by the dietitian to meet nutritional requirements and regulations ...menu	F 803	Conduct weekly in services on portion control . #4 The Finding of the audits will be brought to the Quality Improvement Committee Monthly for 3 months and quarterly thereafter	

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	315291	A. BUILDING _____ B. WING _____	C 05/17/2024

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AVALON REHAB AND CARE CENTER	**2020 ROUTE 23 NORTH WAYNE, NJ 07470**

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F 803	Continued From page 13 items and portion sizes listed on the menu must be served." NJAC 8:39-17.4 (a)3	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061629	A. BUILDING: _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON REHAB AND CARE CENTER	2020 ROUTE 23 NORTH WAYNE, NJ 07470

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S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: C#NJ 148344 C#NJ 148677 C#NJ 149694 C#NJ 150998 C#NJ 151015 C#NJ 155322 C#NJ 156138 C#NJ 157737 C#NJ 159653 C#NJ 159894 C#NJ 160209 C#NJ 160526 C#NJ 161200 C#NJ 165686 C#NJ 168838 C#NJ 169816 C#NJ 169843 C#NJ 170012 C#NJ 167538 C#NJ 170105 C#NJ 172129 C#NJ 172626 C#NJ 173221 Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing rations were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (DOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at 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	S 560	The facility cannot retroactively address the concern mentioned The Director of Nursing and administrator reviewed recruitment procedures that are currently in place. Agency staff is being utilized as needed. We have new hire incentives in place. Nursing and Certified Nurse Aide schools continue to be contacted in an attempt to recruit new graduates. We continue to hire temporary Certified Nurse Aides and assist them in obtaining their certifications. Nursing management is utilized for patient care as needed. Nursing management is rotating on call schedule. The Director of Nursing will monitor staffing on a daily basis and will meet with the staffing coordinator daily to review schedules. The DON will be responsible for verifying there is adequate staffing levels to ensure the facility is meeting the requirements. The Director of Nursing will review recruitment and retention and report results monthly at Quality Assurance Performance Improvement meetings.	7/16/24

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S 560	Continued From page 1 residents for the day shift. 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 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. A review of the "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" completed by the facility for the eight weeks revealed the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: 1. For the week of Complaint staffing from 02/05/2023 to 02/11/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -02/05/23 had 10 CNAs for 118 residents on the day shift, required at least 15 CNAs. -02/06/23 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs. -02/07/23 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -02/07/23 had 7 total staff for 118 residents on the overnight shift, required at least 8 total staff. -02/08/23 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -02/09/23 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs.	S 560		

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S 560	Continued From page 2 -02/10/23 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -02/11/23 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs. 2. For the week of Complaint staffing from 07/09/2023 to 07/15/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -07/09/23 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. -07/10/23 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. -07/11/23 had 12 CNAs for 115 residents on the day shift, required at least 14 CNAs. -07/12/23 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. -07/13/23 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. -07/14/23 had 11 CNAs for 117 residents on the day shift, required at least 15 CNAs. -07/15/23 had 11 CNAs for 117 residents on the day shift, required at least 15 CNAs. 3. For the week of Complaint staffing from 10/29/2023 to 11/04/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -10/29/23 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. -10/30/23 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. -10/31/23 had 11 CNAs for 115 residents on the day shift, required at least 14 CNAs. -11/01/23 had 10 CNAs for 114 residents on the day shift, required at least 14 CNAs. -11/02/23 had 10 CNAs for 114 residents on the day shift, required at least 14 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 3 -11/03/23 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -11/04/23 had 11 CNAs for 114 residents on the day shift, required at least 14 CNAs. 4. For the week of Complaint staffing from 12/17/2023 to 12/23/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -12/17/23 had 10 CNAs for 116 residents on the day shift, required at least 14 CNAs. -12/18/23 had 10 CNAs for 116 residents on the day shift, required at least 14 CNAs. -12/19/23 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. -12/20/23 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. -12/21/23 had 9 CNAs for 116 residents on the day shift, required at least 14 CNAs. -12/22/23 had 11 CNAs for 116 residents on the day shift, required at least 14 CNAs. -12/23/23 had 10 CNAs for 116 residents on the day shift, required at least 14 CNAs. 5. For the week of Complaint staffing from 12/31/2023 to 01/06/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -12/31/23 had 10 CNAs for 124 residents on the day shift, required at least 15 CNAs. -01/01/24 had 11 CNAs for 124 residents on the day shift, required at least 15 CNAs. -01/02/24 had 10 CNAs for 124 residents on the day shift, required at least 15 CNAs. -01/02/24 had 8 total staff for 124 residents on the overnight shift, required at least 9 total staff. -01/03/24 had 11 CNAs for 124 residents on the	S 560		

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S 560	Continued From page 4 day shift, required at least 15 CNAs. -01/04/24 had 7 CNAs for 124 residents on the day shift, required at least 15 CNAs. -01/05/24 had 11 CNAs for 124 residents on the day shift, required at least 15 CNAs. -01/06/24 had 10 CNAs for 124 residents on the day shift, required at least 15 CNAs. 6. . For the week of Complaint staffing from 03/10/2024 to 03/16/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -03/10/24 had 10 CNAs for 134 residents on the day shift, required at least 17 CNAs. -03/11/24 had 9 CNAs for 133 residents on the day shift, required at least 17 CNAs. -03/12/24 had 11 CNAs for 133 residents on the day shift, required at least 17 CNAs. -03/13/24 had 11 CNAs for 133 residents on the day shift, required at least 17 CNAs. -03/14/24 had 11 CNAs for 133 residents on the day shift, required at least 17 CNAs. -03/15/24 had 12 CNAs for 136 residents on the day shift, required at least 17 CNAs. -03/16/24 had 10 CNAs for 136 residents on the day shift, required at least 17 CNAs. 7. For the 4 weeks of Complaint staffing from 03/31/2024 to 04/27/2024, the facility was deficient in CNA staffing for residents on 27 of 28 day shifts and deficient in total staff for residents on 1 of 28 evening shifts as follows: -03/31/24 had 9 CNAs for 126 residents on the day shift, required at least 16 CNAs. -04/01/24 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs. -04/02/24 had 15 CNAs for 126 residents on the day shift, required at least 16 CNAs.	S 560		

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S 560	Continued From page 5 -04/03/24 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -04/04/24 had 15 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/05/24 had 14 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/06/24 had 11 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/07/24 had 11 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/07/24 had 11 total staff for 125 residents on the evening shift, required at least 12 total staff. -04/08/24 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs. -04/09/24 had 8 CNAs for 124 residents on the day shift, required at least 15 CNAs. -04/10/24 had 12 CNAs for 124 residents on the day shift, required at least 15 CNAs. -04/11/24 had 11 CNAs for 123 residents on the day shift, required at least 15 CNAs. -04/12/24 had 13 CNAs for 121 residents on the day shift, required at least 15 CNAs. -04/13/24 had 11 CNAs for 121 residents on the day shift, required at least 15 CNAs. -04/14/24 had 10 CNAs for 121 residents on the day shift, required at least 15 CNAs. -04/15/24 had 13 CNAs for 121 residents on the day shift, required at least 15 CNAs. -04/16/24 had 12 CNAs for 122 residents on the day shift, required at least 15 CNAs. -04/17/24 had 13 CNAs for 122 residents on the day shift, required at least 15 CNAs. -04/18/24 had 10 CNAs for 122 residents on the day shift, required at least 15 CNAs. -04/19/24 had 12 CNAs for 122 residents on the day shift, required at least 15 CNAs. -04/20/24 had 11 CNAs for 122 residents on the day shift, required at least 15 CNAs.	S 560		

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S 560	Continued From page 6 -04/21/24 had 8 CNAs for 122 residents on the day shift, required at least 15 CNAs. -04/22/24 had 11 CNAs for 122 residents on the day shift, required at least 15 CNAs. -04/23/24 had 11 CNAs for 122 residents on the day shift, required at least 15 CNAs. -04/24/24 had 13 CNAs for 122 residents on the day shift, required at least 15 CNAs. -04/25/24 had 6 CNAs for 124 residents on the day shift, required at least 15 CNAs. -04/27/24 had 12 CNAs for 122 residents on the day shift, required at least 15 CNAs. 8. For the 2 weeks of staffing prior to survey from 05/05/2024 to 05/18/2024, the facility was deficient in CNA staffing for 13 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shifts, and deficient in total staff for residents on 2 of 14 overnight shifts as follows: -05/05/24 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs. -05/06/24 had 13 CNAs for 121 residents on the day shift, required at least 15 CNAs. -05/07/24 had 10 CNAs for 120 residents on the day shift, required at least 15 CNAs. -05/08/24 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs. -05/09/24 had 11 CNAs for 120 residents on the day shift, required at least 15 CNAs. -05/09/24 had 8 total staff for 120 residents on the overnight shift, required at least 9 total staff. -05/10/24 had 11 CNAs for 120 residents on the day shift, required at least 15 CNAs. -05/11/24 had 10 CNAs for 114 residents on the day shift, required at least 14 CNAs. -05/12/24 had 8 CNAs for 114 residents on the day shift, required at least 14 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 7 -05/13/24 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -05/15/24 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs. -05/16/24 had 9 CNAs for 118 residents on the day shift, required at least 15 CNAs. -05/17/24 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs. -05/18/24 had 9 CNAs for 118 residents on the day shift, required at least 15 CNAs. -05/18/24 had 8 total staff for 118 residents on the evening shift, required at least 12 total staff. -05/18/24 had 6 total staff for 118 residents on the overnight shift, required at least 8 total staff.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315291 Y1	A. Building B. Wing Y2	6/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON REHAB AND CARE CENTER	2020 ROUTE 23 NORTH WAYNE, NJ 07470

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 F0584	Correction	ID Prefix F0609	Correction	ID Prefix F0761	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	06/30/2024	LSC	06/30/2024	LSC	06/30/2024
ID Prefix F0803	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(c)(1)-(7)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/30/2024	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	
5/17/2024	☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061629		6/30/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON REHAB AND CARE CENTER	2020 ROUTE 23 NORTH WAYNE, NJ 07470

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 06/30/2024	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	
5/17/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO