STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80A113	A. BUILDING: _____ B. WING _____	02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON AT HILLSBOROUGH, THE	393 AMWELL ROAD HILLSBOROUGH, NJ 08844

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Expansion Survey - Application for additional 25 Assisted Living (AL) beds CENSUS: Not occupied (25 beds proposed) Existing AL beds census - 97 SAMPLE: N/A A Life Safety Code Survey was conducted by the State Agency on 02/05/2024. The facility was not in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs.	A 000		
A1081	8:36-16.1(a) Physical Plant (a) The standards in this subchapter shall apply to new construction of assisted living residences or alterations or renovations to existing buildings to create assisted living residences. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to install fire rated glazing in 15 of 15 new fire doors in accordance with the New Jersey Uniform Construction Code. Findings included:	A1081		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80A113	A. BUILDING: _____ B. WING _____	02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON AT HILLSBOROUGH, THE	393 AMWELL ROAD HILLSBOROUGH, NJ 08844

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1081	Continued From page 1 During an observation on 02/05/2024 at 8:49 AM, while conducting a walkthrough of a new addition with the Principal Architect, a newly installed fire door on the third floor was inspected. There was no marking observed on the glazing to determine if the vision panel had fire-rated glazing installed. The only marking observed on the vision panel was for tempered glass. Continued observation during the walkthrough for the timeframe from 8:45 AM through 11:30 AM revealed that the additional fire doors located in stairs one and two, from the basement to the third floor, and the double fire doors located in a smoke barrier in the main corridor on floors one to three were also inspected, and found that there were no markings observed to indicate a fire protection rating on the glazing. There was a total of 15 doors inspected with no markings observed to indicate a fire protection rating on the glazing. The Principal Architect stated that the fire doors were purchased without glazing to avoid damage during construction.	A1081		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
80A113		2/16/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON AT HILLSBOROUGH, THE	393 AMWELL ROAD HILLSBOROUGH, NJ 08844

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 A1081 Reg. # 8:36-16.1(a) LSC	Correction Completed 02/12/2024	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 2/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			