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 03/21/2024

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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F 000	INITIAL COMMENTS Complaint #: NJ 165378; NJ 165506; NJ 165518; NJ 165998; NJ 166074; NJ 166099; NJ 166265; NJ 166624; NJ 168932; NJ 169855 Survey Date: 3/21/24 Census: 91 Sample: 26 + 3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the call bell within reach of the resident. This deficient practice was identified for 1 of 26 residents reviewed for accommodation of needs (Resident #37), and was evidenced by the following: On 3/13/24 at 10:58 AM, the surveyor observed Resident #37 in bed with their eyes open; the resident did not speak but responded to the surveyor's greeting with a smile and waved both	F 558	F558 SS=D Reasonable Accommodations Needs/Preference 1.Immediate Action a. The call bell for resident #37 was immediately repositioned to ensure it was within reach of the resident. b. An audit of all call bell placement was conducted by unit managers for all residents in facility. 2.Identification of Others a. All residents residing in the facility have the potential to be affected by the deficient	3/25/24

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

Electronically Signed | 04/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 558	Continued From page 1 arms. The surveyor observed the resident's call bell (a bell used to summon staff for assistance) was on the floor, not within his/her reach. On 3/15/24 at 11:43 AM, the surveyor observed Resident #37 in bed with the call bell tied to the lower aspect of the right side rail (bar positioned on the side of a bed to assist residents with mobility) not within his/her reach. On 3/19/24 at 9:47 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated the resident used their call bell to alert staff they needed assistance. At that time the surveyor accompanied by the CNA entered Resident #37's room, and they observed the call bell wrapped around the lower part of the side rail, not within his/her reach. The CNA acknowledged the call bell should have been left within the resident's reach, and proceeded to unwrap the call bell and placed it within the resident's reach. The CNA asked the resident to push the call bell, and the surveyor observed them hit the call bell with his/her arm and the light went on. On 3/19/24 at 9:52 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who acknowledged the call bell should be within the resident's reach at all times. The surveyor reviewed the medical record for Resident #37. A review of the Resident Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included respiratory NJ EX Order. 264b1 [redacted]	F 558	practice 3.Systemic changes a. Facility policy for Answering the Call Light policy was reviewed and staff was educated by assistant director of nursing/designee. b. The Unit Manager/designee will conduct daily call light audits for 3 months. 4. Quality monitoring a. The audit results will be reported to the Quality Assurance and Performance Improvement committee on a monthly basis X 6 months for review and further recommendations.	

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F 558	Continued From page 2 NJ EX Order. 264b1 [redacted] A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted] reflected the resident had [redacted] could understand others, was sometimes able to make himself/herself understood, and was dependent on staff for all Activities of Daily Living (ADLs). On 3/20/24 at 1:43 PM, the surveyor informed the above observations with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The DON acknowledged that all residents should have their call bells within reach. A review of the facility's "Answering the Call Light" policy dated revised March 2021, included when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident... NJAC 8:39- 31.8 (c)(9)(10)	F 558		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a.) notify a	F 658	F658 SS=E Services Provided meet professional standards 1.Immediate Action	3/25/24

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F 658	Continued From page 3 physician of a resident's multiple refusals for a NJ EX Order. 264b1 (Resident #68) and b.) maintain and monitor the functionality and the effectiveness of a NJ EX Order. 264b1 since admission to the facility for a resident with a NJ EX Order. 264b1 (Resident #32) in accordance with professional standards of practice. This deficient practice was identified for 2 of 5 residents reviewed for unnecessary medications (Resident #32 and Resident #68). Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." This deficient practice was evidenced by the	F 658	a. Facility policy on Documentation of medication administration policy was reviewed by Director of Nursing and Interdisciplinary team. The resident #68 physician orders reviewed and new orders obtained pertaining to NJ EX Order. 264b1 NJ EX Order. 264b1 Nursing staff educated on documentation on resident refusal of medication and documentation by assistant director of nursing. b. Facility policy on Care of NJ EX Order. 264b1 was reviewed by Administrator and Interdisciplinary team. The resident #32 medical record reviewed by interdisciplinary team and a NJ EX Order. 264b1 appointment was made. 2.Identification of Others a. All residents residing in the facility have the potential to be affected by the deficient practice 3.Systemic changes a. Staff competencies to be completed by assistant director of nursing/designee to address documentation of physician notification on refusals and the Nursing policy and procedure on Documentation was updated. b. The Unit Managers/designee educated the nursing staff on residents with NJ EX Order. 264b1 and all medical records were reviewed for residents with NJ EX Order. 264b1 4. Quality monitoring a. The results will be reported to the Quality Assurance and Performance Improvement committee on a monthly basis X 6 months for review and further recommendations.	

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F 658		F 658		

Continued From page 4

following:

1. On 3/13/24 at 10:50 AM, the surveyor observed Resident #68 seated in a wheelchair, who stated he/she had NJ EX Order. 264b1 and used a wheelchair to get around the building.

The surveyor reviewed the medical record for Resident #68.

A review of the Resident Face Sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included NJ EX Order. 264b1 .

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ EX Order. 264b1, reflected a brief interview for mental status (BIMS) score of NJ EX Order. 264b1; which indicated a fully NJ EX Order. 264b1

A review of the individual comprehensive care plan included a focus area dated initiated NJ EX Order. 264b1 for NJ EX Order. 264b1. Interventions included my diabetes will be managed through a combination of NJ EX Order. 264b1 and we will administer NJ EX Order. 264b1 as ordered.

A review of the NJ EX Order. 264b1 Physician's Orders report included a physician order (PO) dated NJ EX Order. 264b1 with a renewal date of NJ EX Order. 264b1, for NJ EX Order. 264b1 NJ EX Order. 264b1 route once daily (4:30 PM) before dinner as per NJ EX Order. 264b1: NJ EX Order. 264b1

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F 658	Continued From page 5	F 658		

A review of the corresponding NJ EX Order: 26461 Medication Administration Record (MAR) reflected the following:

From NJ EX Order: 2 to NJ EX Order: 26, the nurse had indicated the star symbol (*). According to the chart codes "*" indicated "Not administered (see last section)".

A review of the last section of the NJ EX Order: 26461 MAR revealed the resident had refused the NJ EX Order: 26461 on 3/1, 3/2, 3/3, 3/4, 3/5, 3/8, 3/11, 3/13, 3/14, 3/15, 3/16 and 3/17.

A review of the corresponding Progress Notes for NJ EX Order: 26461 did not include documentation that the resident had refused his/her NJ EX Order: 26461 medication, or that the resident's physician had been notified of their refusal of the NJ EX Order: 26461 medication.

On 3/19/24 at 11:09 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated the nurse contacted a resident's physician if a resident refused medication. At that time the surveyor and the UM/LPN reviewed Resident #68's NJ EX Order: 26461 MAR, and the UM/LPN acknowledged the resident had refused NJ EX Order: 2 on multiple occasions. The UM/LPN stated she needed to review the resident's progress notes and the 24-hour Nursing Report (a shift-to-shift communication resource for nurses regarding residents' current statuses) to see if a nurse had documented the physician had been notified of the medication refusal.

On 3/19/24 at 12:02 PM, the surveyor and the UM/LPN reviewed the 24-hour Nursing Report as

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F 658	Continued From page 6	F 658		

well as March 2024 nursing Progress Notes, which neither included any documentation that Resident #68's physician had been notified of their refusal of [redacted].

On 3/19/24 at 1:48 PM the surveyor interviewed the Director of Nursing (DON) who stated if a resident refused medication, the nurse educated the resident and encouraged the resident to take their medication. If a resident continued to refuse his/her medication, then the nurse contacted the physician. The DON stated the nurse documented the resident's medication refusal in the nursing Progress Notes, and once the physician was notified, they documented that as well. At this time the surveyor with the DON reviewed the resident's [redacted] 4 MAR, and the DON acknowledged the resident refused their [redacted]. The DON stated the nurse should have contacted the physician to see how to proceed. The DON stated she needed to review the resident's medical record for further information.

On 3/20/24 at 1:49 PM, the DON stated she was still reviewing the nursing Progress Notes and had not found any documentation which indicated the physician had been notified, but she was still checking.

On 3/21/24 at 11:02 AM, the survey team met with the DON and Licensed Nursing Home Administrator (LNHA), and the DON confirmed there was no documentation the physician had been made aware the resident had been refusing their [redacted] medication.

A review of the facility's "Administering Medications" policy dated revised April 2019, did

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F 658	Continued From page 7	F 658		

not include instructions for medication refusal.

A review of the facility's "Charting and Documentation" policy dated revised July 2017, did not include instructions for medication refusal.

A review of the facility's "Documentation of Medication Administration" policy dated revised April 2007, did not include instructions for medication refusal.

2. On 3/15/24 at 9:43 AM, the surveyor observed Resident #32 lying in bed awake, and the resident stated they were comfortable.

A review of the Resident Face Sheet reflected the resident was admitted to the facility with diagnoses that included a NJ EX Order. 264b1 [redacted]).

A review of the most recent quarterly MDS dated 2/2/24, reflected a BIMS score of [redacted] which indicated severe cognitive impairment.

A review of the [redacted] Physician's Orders report included a general order dated [redacted], for a pacemaker at the left chest wall with no further indications to monitor the [redacted].

A review of the individualized comprehensive care plan, dated effective [redacted], included a focus for [redacted] with goals that included maintaining adequate [redacted] function and the

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F 658		F 658		

Continued From page 8

NJ EX Order 264b1 will continue to function properly. There were no interventions included for this focus. Further review revealed a focus dated NJ EX Order 26, for a NJ EX Order 264b1 that indicated "no goals exit for this focus"; "no interventions exist for this focus", and "no notes exist for this focus."

On 3/19/24 at 1:28 PM, the surveyor interviewed the UM/LPN who stated that if a resident had a NJ EX Order 264b1, it would be checked for function. The UM/LPN was unable to locate any NJ Ex Order 264b1 checks performed for Resident #32.

On 3/19/24 at 1:35 PM, the surveyor interviewed the DON who stated that the facility was responsible for ensuring NJ EX Order 264b1 were checked according to the physician's orders.

On 3/21/24 at 10:00 AM, the surveyor re-interviewed the DON who acknowledged that the facility did not have NJ EX Order 264b1 checks for Resident #32, and the facility was unable to identify the type of NJ EX Order 264b1 the resident had. The DON stated that the resident's physician and family members did not know the type of NJ EX Order 264b1 the resident had; that the NJ EX Order 264b1 was inserted prior to admission to the facility.

On 3/21/24 at 11:02 AM, the DON in the presence of the LNHA and the surveyor team, stated there was no further information regarding the NJ EX Order 264b1 and confirmed it was essential to know the type of NJ EX Order 264b1 the resident had to ensure it was maintained according to manufacturer's specifications.

A review of the facility's NJ EX Order 264b1, Care of a Resident with" procedure dated December 2021, included ...monitoring the resident for NJ EX Order 264b1

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F 658	Continued From page 9 NJ EX Order by monitoring for signs of NJ EX Order. 264b1 [NJ EX Order. 264b1 that may consist of NJ EX Order. 264b1 ...Documentation in the medical records on the NJ EX Order. 264b1 identification card upon admission ...the name and address of the NJ EX Order. 264b1, type of NJ EX Order. 264b1, manufacturer, and model, serial number, date of NJ EX Order. 264b1 and NJ EX Order. 264b1	F 658		
F 692 SS=D	NJAC 8:39-27.1(a)-29.2(d) Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of	F 692	F692 SS=D Nutrition/Hydration Status	3/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 692	Continued From page 10 pertinent facility documents, it was determined that the facility failed to ensure the accuracy of a re-admission nutrition assessment for a resident with significant [redacted]. This deficient practice was identified for 1 of 4 residents reviewed for nutrition (Resident #60), and was evidenced by the following: On 3/13/24 at 9:46 AM, the surveyor observed Resident #60 in bed who stated he/she just finished breakfast and was still hungry. At this time, the surveyor observed the Licensed Practical Nurse (LPN) deliver the resident a sandwich. The surveyor reviewed the medical record for Resident #60. A review of the Resident Face Sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses which included NJ EX Order. 264b1 [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected the resident had a brief interview for mental status (BIMS) score of [redacted] out of [redacted]; which indicated a NJ EX Order. 264b1 A review of the Resident Progress Notes included a nursing note dated [redacted] at 11:09 PM, that the resident was admitted to the facility from the hospital. A review of the dietary note dated [redacted] at 11:36 AM, that the Registered Dietitian (RD)	F 692	Maintenance a. The Resident #60 was reassessed by Registered Dietitian for NJ EX Order. 264b1 and an order for NJ EX Order. 264b1 was put in place. The resident was re-weighed for accuracy. 2.Identification of Others a. All residents residing in the facility have the potential to be affected by the deficient practice 3.Systemic changes a. Facility weight policy was reviewed and nursing staff was re-educated by assistant director of nursing/designee. b. The lead Registered Dietitian/designee will audit the facility Registered Dietitian to ensure the accuracy of all new and re-admission nutrition assessments for 3 months. 4. Quality monitoring a. The audit results will be reported to the Quality Assurance and Performance Improvement committee on a monthly basis X 6 months for review and further recommendations.	

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F 692	Continued From page 11	F 692		

assessed the resident for a NJ EX Order. 264b1 pounds (.lbs) which was [redacted] since [redacted] which was a significant NJ EX Order. 264b1 greater than [redacted] in one month.

A review of the resident's weights indicated the following:

1/9/24 [redacted].lbs
2/6/24 [redacted].lbs
3/13/24 [redacted].lbs

The weights did not include an NJ EX Order. 264b1 on [redacted], when the resident was re-admitted from the hospital.

A review of the Dietary-Readmission/Quarterly Assessment dated [redacted]4, included the resident's current body weight was [redacted].lbs on [redacted]4, with a one month NJ EX Order. 264b1 of [redacted].lbs or [redacted] since [redacted]. This assessment did not include a current weight since re-admission.

On 3/21/24 at 10:13 AM, the surveyor interviewed the RD who stated he completed nutrition assessments for the residents upon admission, re-admission, quarterly, and annually. The RD stated part of the assessment was to assess if the resident lost a significant amount of weight which would be 5% in one month; 7.5% in three months, and 10% or more in six months. The RD stated weights were obtained monthly usually by the fifth of the month and reweights if concern with accuracy were obtained by the eighth of the month. If the resident was admitted or re-admitted to the facility, and no weight was obtained yet, he would ask staff for the resident to be weighed. The RD stated the assessment could not be based on a hospital or previous

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 692	Continued From page 12	F 692		

weight; the weight needed to be current from admission. At this time, the surveyor reviewed Resident #60's Dietary-Readmission/Quarterly Assessment dated [redacted], and the RD confirmed the weight used for the assessment was not the resident's current weight, but the weight from the previous month prior to hospitalization. The RD stated at the time of the assessment, the resident's weight was not obtained, and acknowledged the assessment should have been based on a current weight for accuracy. The RD stated that the resident was weighed on [redacted] (twelve days after admission), and had a significant weight loss so one of the interventions he added was double protein portions at all meals for the resident.

The surveyor continued to review the medical record.

A review of the [redacted] Progress Notes included a physician's order dated [redacted] for [redacted] at all meals.

On 3/21/24 at 11:02 AM, the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team stated that a resident's weight should be obtained upon admission, and the weight used in the nutrition assessment should be the resident's current weight.

On 3/21/24 at 11:58 AM, the Lead RD in the presence of the RD informed the survey team that Resident #60 was re-admitted to the facility on [redacted] and at the time of the nutrition assessment, there was no re-admission weight so the RD used the previous weight. The Lead RD continued the RD was out of the facility and

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 03/21/2024

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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F 692	Continued From page 13	F 692		

upon return observed the resident had a significant weight loss, so he wrote a dietary note on [redacted] to address the [redacted]. The Lead RD confirmed the re-admission nutrition assessment from [redacted] was not accurate since the weight used was prior to re-admission.

A review of the facility's "Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol" policy dated revised September 2017, included... The staff and physician will define the individual's current nutritional status (weight, food/fluid intake, and pertinent laboratory values) and identify individuals with anorexia, weight loss or gain, and significant risk for impaired nutrition ...The physician will consider whether any assessment including additional diagnostic testing is indicated to help clarify the severity or consequence of weight loss/or impaired nutrition.

A review of the facility's "Food and Nutrition Services", dated revised October 2017, included ... Each resident is provided with a nourishing palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident: The multidisciplinary staff, including nursing staff, the attending physician and the dietician will assess each resident's nutritional needs, food likes, dislikes and eating habits, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization...

A review of the facility's "Nutritional Assessment", dated revised October 2017, included...As part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factor for impaired nutrition, shall be

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 03/21/2024

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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F 692	Continued From page 14 conducted for each resident...The Dietitian, in conjunction with the nursing staff and healthcare practitioner, will conduct a nutritional assessment for each resident upon admission (with current baseline assessment timeframes) and as indicated by a change in condition that places the resident at risk for impaired nutrition... NJAC 8:39-27.1(a); 27.2(a)	F 692		
F 698 SS=E	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, and review of pertinent facility documents, it was determined that the facility failed to a.) consistently complete the dialysis communication form and b.) maintain a resident's [NJ EX Order 264] communication record. This deficient practice was identified for 1 of 2 residents reviewed for [NJ EX Order 264] (Resident # 60), and was evidenced by the following: On 3/13/24 at 9:46 AM, the surveyor observed Resident #60 in bed in their room, who stated he/she went to [NJ EX Order 264] on [NJ EX Order 264b2] [redacted]. The surveyor reviewed the medical record for Resident #60.	F 698	F698 SS=E Dialysis 1.Immediate Action a. Resident #60 [NJ EX Order 264] communication book was reviewed by unit managers and all findings corrected. The nursing staff was educated by assistant director of nursing/designee. 2.Identification of Others a. All residents residing in the facility have the potential to be affected by the deficient practice 3.Systemic changes a. The facility has implemented a new process for ongoing communication documentation with the [NJ EX Order 264b1] center which includes the following: The nurse will be responsible for maintaining	3/25/24

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 03/21/2024

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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F 698	Continued From page 15 A review of the Resident Face Sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses which included NJ EX Order. 264b1 [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected a brief interview for mental status (BIMS) score of [redacted], which indicated an NJ EX Order. 264b1. A further review in "Section O - Special Treatment and Procedures" reflected that the resident received NJ EX Order. 264b1 services (NJ EX Order. 264b1 [redacted]). A review of the Physician's Orders for [redacted] included a physician order (PO) dated [redacted] for NJ EX Order. 264b1 [redacted] from 3:00 PM to 11:00 PM. A review of the individualized comprehensive care plan included a focus area dated [redacted], that the resident was at risk for complications related to NJ EX Order. 264b1 services. Interventions included to ensure that you are prepared to attend [redacted] as ordered; monitor you for [redacted] every shift upon return from [redacted]; take your vital sign pre and [redacted] on [redacted] days; take your [redacted] as ordered on [redacted] days both pre and post [redacted] and notify your [redacted] center of any changes in your condition via communication book or telephone as needed. On 3/15/24 at 10:58 AM, the surveyor requested from the Unit Manger/Licensed Practical Nurse (UM/LPN) the resident's [redacted] communication	F 698	the [redacted] communication book for each resident receiving [redacted] services. A protocol was developed for ongoing communication and documentation for the nursing staff. The policy was reviewed and signed off by medical director. The nursing staff was educated by the Director of Nursing/designee. b. The Unit Manager/designee will audit all [redacted] communication books for completeness daily for 3 months. 4. Quality monitoring a. The audit results will be reported to the Quality Assurance and Performance Improvement committee on a monthly basis X 6 months for review and further recommendations.	

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 03/21/2024

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 698	Continued From page 16	F 698		

record. The UM/LPN stated he was unsure where the resident's communication record was; he thought the record had possibly been left at dialysis or with the transport company.

At this time the surveyor reviewed the resident's paper medical record which included the following incomplete NJ EX Order. 264b1 Communication forms (DCF) for the section "To be completed by facility Nurse upon return" which included: time returned to the facility; NJ EX Order. 264b1 access site location; access site assessment NJ EX CNJ EX Order. 264b1 intact/no signs of NJ EX Order. 264b1; vital signs; nurse signature and date were not completed as followed:

12/4/23,12/8/23, 12/13/23, 12/31/23, 1/17/24, 1/19/24, 1/22/24, 1/24/24, 1/26/24, 1/29/24, 2/2/24, 2/9/24, 2/12/24, 2/14/24, 2/16/24, 2/19/24, 3/4/24, 3/6/24, 3/12/24 and 3/13/24.

On 3/15/24 at 11:00 AM, the surveyor interviewed the UM/LPN who stated the facility was unable to locate the resident's NJ EX Order. 264b1 communication record, so the facility obtained copies of the records from NJ EX Order. 264 and created a new book. The UM/LPN acknowledged the nurses should have completed the "To be completed by the facility Nurse upon return" section.

On 3/20/24 at 11:15 AM, the surveyor interviewed Resident #60 who stated upon return from dialysis, the nurses sometimes assessed him/her. The resident stated the nurses sometimes checked his/her NJ EX Order. 264b1 and their NJ EX Order. 264b1.

On 3/21/24 at 9:10 AM, the Director of Nursing (DON) in the presence of the Licensed Nursing

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 03/21/2024

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 698	Continued From page 17 Home Administrator (LNHA) and survey team acknowledged the resident's [redacted] Communication forms were not completed upon return from the facility. The DON stated the nurses needed to assess the resident upon return to the facility, and documenting on the forms. A review of the facility's " NJ EX Order. 264b1 [redacted] Care of a Resident with " policy dated 9\September 2010, included...the following residents with NJ EX Order. 264b1 will be cared for according to currently recognized standards of car ...the residents comprehensive care plan will reflect the resident's needs related to NJ EX Order. 264b1 care. The policy did not address the facility nurses responsibility to complete the DCF forms once the resident returns to facility...	F 698		
F 727 SS=D	NJAC 8:39-27.1(a) RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:	F 727		3/25/24

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 03/21/2024

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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F 727	Continued From page 18 Based on interview, review of Nurse Staffing Report sheets, and other pertinent facility documents, it was determined that the facility failed to ensure a Registered Nurse worked seven days a week for at least eight consecutive hours a day for 4 of 21 days reviewed. This deficient practice was evidenced by the following: During entrance conference on 3/13/24 at 10:45 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) how the facility's staff was, and the LNHA stated that staffing was good; that the facility primarily utilized agency staff for certified nursing aides (CNA). At this time, the surveyor requested the Nurse Staffing Report to be completed for the following weeks: 6/25/23 through 7/1/23; 7/2/23 through 7/8/23; 3/3/24 through 3/9/24. The surveyor reviewed the Nurse Staffing Reports which revealed there was no Registered Nurse (RN) to work eight consecutive hours on the following dates: 1. No RN on 6/25/23; the last RN was scheduled on the 3:00 PM to 11:00 PM (3-11) shift on 6/24/23. 2. No RN on 7/2/23; the last RN was scheduled on the 7:00 AM to 3:00 PM (7-3) shift on 7/1/23. 3. No RN on 7/8/23; the last RN was scheduled on the 3-11 shift on 7/7/23. 4. No RN on 3/4/23; the last RN was scheduled on the 11:00 PM to 7:00 AM (11-7) shift on 3/3/24. A review of the corresponding nursing staffing	F 727	F727 SS=D RN 8 Hours/7 days/Week, Full Time DON 1.Immediate Action a. The staffing coordinator and interdisciplinary team received education by the director of nurse ensuring an RN was scheduled for at least 8 consecutive hours a day, 7 days a week. 2.Identification of Others a. All residents residing in the facility have the potential to be affected by the deficient practice 3.Systemic changes a. The Director of nursing/designee will conduct daily audits for 3 months to ensure the facility has an RN scheduled for 8 consecutive hours a day, 7 days a week. 4. Quality monitoring a. The audit results will be reported to the Quality Assurance and Performance Improvement committee on a monthly basis X 6 months for review and further recommendations.	

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 03/21/2024

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 727	Continued From page 19	F 727		

sheets verified the following:

During the 3-11 shift on 6/24/23, there was a RN scheduled, and the next RN scheduled to work on the 7-3 shift on 6/26/23.

During the 3-11 shift on 7/1/23, there was a RN scheduled, and the next RN scheduled to work was on the 3-11 shift on 7/3/23.

During the 3-11 shift on 7/7/23, there was a RN scheduled, and the next RN scheduled to work was on the 3-11 shift on 7/9/23.

During the 11-7 shift on 3/3/24, there was a RN scheduled, and the next RN scheduled to work was on the 7-3 shift on 3/5/24.

On 3/20/24 at 10:26 AM, the surveyor interviewed the Staffing Coordinator who stated the RNs scheduled in the building during the shifts were usually the supervisors. The Staffing Coordinator confirmed there should be a RN in the building daily for eight consecutive hours.

On 3/21/24 at 11:02 AM, the DON in the presence of the LNHA and survey team, confirmed there was no RN in the facility for eight consecutive hours on the dates above.

A review of the facility's "Staffing" policy dated revised October 2017, included our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services in accordance with resident care plans and the facility assessment...

NJAC 8:39-25.2(h)

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 03/21/2024

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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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		3/25/24

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 03/21/2024

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 880	Continued From page 21 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain infection control standards and procedures during a [redacted] care treatment. This deficient practice was identified for 1 of 2 wound observations observed for 1 of 2 residents reviewed for [redacted] and injury (Resident #56), and was evidenced by the following: On 3/13/24 at 10:25 AM, the surveyor observed	F 880	F880 SS=D Infection Prevention and Control 1.Immediate Action a. Facility policy on handwashing was reviewed by Administrator and Interdisciplinary team. UM/LPN was re-educated by and a competency on hand washing was completed by the infection preventionist. b. Facility policy on cleaning and disinfecting surfaces was reviewed by	

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	315455	A. BUILDING _____ B. WING _____	C 03/21/2024

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 880	Continued From page 22 Resident #56 in bed with a NJ EX Order. 264b1 device who stated he/she had a NJ EX Order. 264b1 on his/her NJ EX Order. 264b1. The surveyor reviewed the medical record for Resident #56. A review of the Resident Face Sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses that included NJ EX Order. 264b1 A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ EX Order. 264b1, revealed a NJ EX Order. 264b1 NJ EX Order. 264b1 A review of the Physician's Orders included a physician's order (PO) dated NJ EX Order., to cleanse the NJ EX Order. 264b1 with a NJ EX Order. 264b1 cleansing solution; apply NJ EX Order. 264b1 (used to aid in NJ EX Order. 264b1 rder. 264b1); and apply a NJ EX Order. 264b1 daily. On 3/19/24 at 10:50 AM, the surveyor observed the Unit Manager/Licensed Practical Nurse (UM/LPN) perform a NJ EX Order. 26 care treatment on Resident #56 and observed the following: The UM/LPN entered the resident's room and placed the NJ EX Order. 2 treatment supplies directly on the resident's overbed table without first sanitizing	F 880	Administrator and Interdisciplinary team. UM/LPN was re-educated by infection preventionist. c. Facility policy on aseptic dressing technique was reviewed by Administrator and interdisciplinary team. UM/LPN was re-educated and a competency on NJ EX Order. 2 care NJ EX Order. 264b1 was completed by the infection preventionist. 2.Identification of Others a. All residents residing in the facility have the potential to be affected by the deficient practice. 3.Systemic change a. The infection preventionist will re-educate the nursing staff on hand washing techniques. b. The infection preventionist will complete hand washing competency on all nursing staff. c. The infection preventionist will complete NJ EX Order. 26 dressing competency on all nursing staff. d. The infection preventionist will re-educate the nursing staff on our policy on cleaning and disinfecting surfaces 4. Quality monitoring a. The infection preventionist nurse/designee will continue to observe hand washing technique and wound treatments 5 times a day for 3 months. The audit results will be reported to the Quality Assurance and Performance Improvement committee on a monthly basis X 6 months for review and further recommendations.	

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 03/21/2024

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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F 880	Continued From page 23	F 880		

or applying a clean barrier. The UM/LPN proceeded to date and initial the [NJ EX Order. 264b1], then left the room to retrieve the [NJ EX Order. 264b1].

At 10:58 AM, the UM/LPN reentered Resident #56's room and washed his hands with soap and water lathering under the flow of running water for thirteen seconds. The UM/LPN then put on gloves; cleaned the resident's [NJ EX Order. 2] and without changing his gloves or performing hand hygiene, applied [NJ EX Order. 264b1] on the [NJ EX Order. 264b1] and covered the [NJ EX Order. 2] with a NJ EX Order. 264b1 The UM/LPN then removed his gloves, washed his hands with soap and water lathering outside the flow of running water for eight seconds; then put on a new pair of gloves, and repositioned the resident. The UM/LPN then removed his gloves and performed hand hygiene lathering with soap outside the flow of running water for eleven seconds.

At 1:16 PM, the surveyor interviewed the UM/LPN who confirmed he should have changed his gloves and washed his hands after cleaning the [NJ EX Order. 2] prior to performing the treatment. The UM/LPN also acknowledged he should have sanitized the table and put down a clean barrier prior to putting the supplies on it, and he should have washed his hands for the length of time it took to sing two "Happy Birthday songs". The UM/LPN was not aware of the exact timeframe that hands should be lathered with soap outside the flow of running water.

On 3/21/24 at 11:02 AM, the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team confirmed the overbed table should have been sanitized prior to placing the [NJ EX Order. 2] care supplies

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 03/21/2024

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(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 880	Continued From page 24	F 880		

on it, and the nurse should have lathered his hands with soap and water outside the flow of running water for twenty seconds.

A review of the facility's "Handwashing/Hand Hygiene," policy dated revised August 2019, included the facility considers hand hygiene the primary means to prevent the spread of infections ...washing hands ...wet hands first with water, then apply an amount of product recommended by the manufacturer to hands... rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers, rinse hands with water and dry thoroughly with a disposable towel...

A review of the facility's [redacted] Care" policy dated revised October 2010, included the purpose of this procedure is to provide guidelines for the care of [redacted] to promote healing ...steps in the procedure ...use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during the procedure on the clean field...be sure all clean items are on the clean field ...use clean field saturated with alcohol to wipe the overbed table...

A review of the facility's [redacted] Care Clean Dressing Change Competency Skills Checklist included...wipe table clean with appropriate surface cleanser, let dry, put down protective barrier...open treatment supplies on clean barrier...apply treatment to [redacted] as ordered...discard protective barrier and gloves and perform hand hygiene...wipe down bedside table with appropriate surface cleanser and discard in plastic bag...perform hand hygiene...

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 03/21/2024

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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F 880	Continued From page 25 NJAC 8:39-19.4(a)	F 880		

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 03/21/2024

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) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 26 out of 42 shifts day shifts and 1 out of 42 overnight shifts reviewed. This deficient practice was evidenced by the following: 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 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	S 560	S560 Mandatory Access to Care 1.Immediate Action The Director of Nursing and the administrator 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 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	3/25/24

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

Electronically Signed | 04/08/24

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 03/21/2024

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 560	Continued From page 1 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 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. During entrance conference on 3/13/24 at 10:45 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) how the facility's staff was, and the LNHA stated that staffing was good; that the facility primarily utilized agency staff for certified nursing aides (CNA). At this time, the surveyor requested the Nurse Staffing Report to be completed for the following weeks: 6/25/23 to 7/1/23; 7/23/23 to 8/5/23; and 2/25/24 to 3/9/24. The surveyor reviewed the facility completed Nurse Staffing Reports which revealed the following: 1. For the two weeks of staffing from 6/25/23 to 7/1/23, the facility was deficient in CNA staffing for residents on 14 out of 14 day shifts as follows: 6/25/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs.	S 560	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 6 months for review and further recommendations.	

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 03/21/2024

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

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S 560	Continued From page 2 6/26/23 gad 8 CNAs for 89 residents on the day shift, required at least 11 CNAs. 6/27/23 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs. 6/28/23 had 8 CNAs for 87 residents on the day shift, required at least 11 CNAs. 6/29/23 had 8 CNAs for 87 residents on the day shift, required at least 11 CNAs. 6/30/23 had 7 CNAs for 87 residents on the day shift, required at least 11 CNAs. 7/1/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. 7/2/23 had 6 CNAs for 90 residents on the day shift, required at least 11 CNAs. 7/3/23 had 6 CNAs for 88 residents on the day shift, required at least 11 CNAs. 7/4/23 had 7 CNAs for 88 residents on the day shift, required at least 11 CNAs. 7/5/23 had 8 CNAs for 84 residents on the day shift, required at least 10 CNAs. 7/6/23 had 8 CNAs for 84 residents on the day shift, required at least 10 CNAs. 7/7/23 had 7 CNAs for 84 residents on the day shift, required at least 10 CNAs. 7/8/23 had 5 CNAs for 84 residents on the day shift, required at least 10 CNAs. 2. For the two weeks of staffing from 7/23/23 to 8/5/23, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows: 7/23/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. 7/24/23 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs. 7/27/23 had 8 CNAs for 88 residents on the day shift, required at least 11 CNAs. 7/28/23 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. 7/29/23 had 10 CNAs for 88 residents on the day	S 560		

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 03/21/2024

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

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S 560	Continued From page 3	S 560		

shift, required at least 11 CNAs.
7/30/23 had 8 CNAs for 91 residents on the day shift, required at least 11 CNAs.
7/31/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs.
8/5/23 had 8 CNAs for 89 residents on the day shift, required at least 11 CNAs.

3. For the two weeks of staffing from 2/25/24 to 3/9/24, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows:

2/25/24 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs.
2/28/24 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs.
3/3/24 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs.
3/4/24 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs.
3/4/24 had 5 total staff for 91 residents on the overnight shift, required at least 6 total staff.

On 3/20/24 at 10:26 AM, the surveyor interviewed the Staffing Coordinator who stated she staffed CNAs based on the resident census in accordance with state regulations. The Staffing Coordinator stated the facility was required to schedule one CNA to every eight residents during the day shift; one CNA to every ten residents during the evening shift; and one CNA for every fourteen residents during the overnight shift. The Staffing Coordinator stated she was usually able to schedule CNAs to meet the ratios with no issues.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
60a005 Y1	A. Building B. Wing Y2	5/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS AT MORRISTOWN	17 SPRING PLACE MORRISTOWN, NJ 07960

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 A0235	Correction	ID Prefix A0310	Correction	ID Prefix A0357	Correction
Reg. # 8:36-2.4(d)	Completed	Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(2)	Completed
LSC	04/15/2024	LSC	03/08/2024	LSC	03/08/2024
ID Prefix A0389	Correction	ID Prefix A0547	Correction	ID Prefix A0709	Correction
Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-5.7(a)(6)	Completed	Reg. # 8:36-7.2(d)(1-18)	Completed
LSC	03/08/2024	LSC	03/08/2024	LSC	03/08/2024
ID Prefix A0963	Correction	ID Prefix A1023	Correction	ID Prefix A1051	Correction
Reg. # 8:36-11.5(f)	Completed	Reg. # 8:36-14.1(a)	Completed	Reg. # 8:36-15.2	Completed
LSC	04/12/2024	LSC	03/08/2024	LSC	04/15/2024
ID Prefix A1235	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.5(a)(3)(i-ii)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/15/2024	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	
3/14/2024	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
60a005 Y1	A. Building B. Wing Y2	5/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS AT MORRISTOWN	17 SPRING PLACE MORRISTOWN, NJ 07960

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0235	Correction	ID Prefix A0310	Correction	ID Prefix A0357	Correction
Reg. # 8:36-2.4(d)	Completed	Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(2)	Completed
LSC	04/15/2024	LSC	03/08/2024	LSC	03/08/2024
ID Prefix A0389	Correction	ID Prefix A0547	Correction	ID Prefix A0709	Correction
Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-5.7(a)(6)	Completed	Reg. # 8:36-7.2(d)(1-18)	Completed
LSC	03/08/2024	LSC	03/08/2024	LSC	03/08/2024
ID Prefix A0963	Correction	ID Prefix A1023	Correction	ID Prefix A1051	Correction
Reg. # 8:36-11.5(f)	Completed	Reg. # 8:36-14.1(a)	Completed	Reg. # 8:36-15.2	Completed
LSC	04/12/2024	LSC	03/08/2024	LSC	04/15/2024
ID Prefix A1235	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.5(a)(3)(i-ii)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/15/2024	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	
3/14/2024	☐ 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 (Y2)	DATE OF REVISIT (Y3)
60a005	A. Building B. Wing	5/9/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS AT MORRISTOWN	17 SPRING PLACE MORRISTOWN, NJ 07960

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 H2640 Reg. # 8:43E-10.6(a)(2)(i) LSC	Correction Completed 03/08/2024	ID Prefix H5750 Reg. # 8:43E-13.4(b) LSC	Correction Completed 04/12/2024	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

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
3/14/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**