STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315223	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Rehabilitation and Healthcare Center	1059 Edinburg Road Hamilton, NJ 08690

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, review of the medical record and other facility documentation, it was determined that the facility failed to follow fall prevention interventions as written on the resident's plan of care. This deficient practice was identified for 1 of 4 residents (Resident #120) reviewed for accidents. This deficient practice was evidenced by the following: On 11/20/2025 at11:50 AM, the surveyor observed Resident #120 in bed. There was a fall mat on the floor to the right side of the bed. The surveyor reviewed the electronic medical record (EMR) for Resident #120.A review of the admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; unspecified dementia, unspecified severity, without behavioral disturbance psychotic disturbance, mood disturbance (a mental disorder that can cause a person to lose the ability to learn, remember, think, solve problems, and make decisions) and Type 2 Diabetes Mellitus with Diabetic Chronic kidney disease (a condition in which the body has trouble controlling blood sugar that can affect the kidneys). A review of the Minimum Data Set (MDS), an assessment tool dated 10/3/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) of 00 out of 15, indicating the resident's cognition was unable to be assessed. A review of the individual comprehensive care plan (ICCP) revealed a focus of at risk for falls; Fall mat to exit side of the bed at all times when the resident is in bed. Date Initiated: 05/28/2024. A review of the Order Summary Report revealed a physician's order for Floor Mats to exit side of the bed when resident in bedevery shift, dated 2/29/2024. On 11/24/2025 at 8:58 AM, the surveyor observed Resident #120 in bed eating breakfast. The surveyor observed the fall mat leaning against the wall. On 11/25/2025 at 11:43 AM, the surveyor observed Resident #120 in bed, with their eyes closed. The surveyor observed the fall mat against the wall. On 11/25/2025 at 2:20 PM, the surveyor interviewed Registered Nurse (RN) #1, who stated the resident's aide was on break. RN #1 stated Resident #120 was at risk for falls and should have a fall mat on the floor. RN #1 and the surveyor walked to Resident #120's room and observed the fall mat resting on the wall between the resident's bed and the wall. RN # 1 stated the residents bed is broken that is why the mat is not on the floor. She added she needed to follow up with maintenance because they haven't come to fix the bed yet. RN #1 stated fall mats were used for resident safety. She stated fall mats should be down at all times while the resident was in bed. RN #1 was unable to explain why the bed being broken meant the fall mat did not need to be down next to the bed.On 11/25/2025 at 2:30PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM), who stated if the resident had a physician order for fall mats while a resident was in bed, that meant the fall mats should be down. On 11/26/2025 at 8:18 AM, the surveyor interviewed the DON, who stated if the resident had a physician order for fall mats while the resident was in bed, that meant the fall mats should be down when the resident was in bed. She stated fall mats were to prevent injuries and should be used unless the staff was doing care. On 11/26/2025 at12:45 PM, the surveyor made the Licensed Nursing Home Administrator (LNHA), the Regional Director of Operations (RDO), the DON, and the Assistant DON aware of the above mentioned concern. NJAC 8:39-27. 1 (a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint # NJ 2601539 Based on observation, interview and record review, it was determined that the facility failed to provide care and services in accordance with professional standards by adjusting medication, nourishment supplementation and monitoring administration times to accommodate for dialysis (a medical treatment that removes waste products and excess fluid from the blood when the kidneys are unable to do so) scheduled times and was not administered on nine (9) dialysis days from an admission in August 2025 until discharged in September 2025. 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. The deficient practice was identified for one (1) of two (2) residents, (Resident #166), reviewed for dialysis services and was evidenced by the following: The surveyor reviewed the closed electronic medical record for Resident #166. A review of the admission Record revealed diagnoses that included, but not limited to; acute kidney disease, end stage renal disease (ESRD) (a condition which the kidneys cannot filter waste from the blood), dependence on renal dialysis (a mechanical process used to filter waste from the blood), anemia (low levels of healthy red blood cells) in chronic kidney disease (CKD), heart failure, hypertension (high blood pressure), Type 2 Diabetes Mellitus (DM) (chronic condition the body does not use insulin properly leading to high blood sugar levels) with diabetic chronic kidney disease and Type 1 Diabetes Mellitus (chronic condition the body does not produce insulin leading to high blood sugar levels requiring the use of insulin) with diabetic neuropathy (nerve damage caused by high blood sugar levels over a long period usually affecting legs and feet). A review of a comprehensive admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of 8/19/2025, reflected the resident had a brief interview for mental status (BIMS) score of 15 out of 15, indicating that the resident had an intact cognition. A review of the resident's individualized interdisciplinary care plan revealed a focus area, with an initiated date of 8/12/25, I am on pain medication therapy. The intervention indicated Administer medication as ordered. Another focus area initiated 8/12/25 revealed I need hemodialysis r/t (related to) ESRD. In addition, a focus area initiated 8/13/25 I have a nutritional problem or potential nutritional problem r/t CHF (congestive heart failure), CKD, Diabetes Mellitus, ESRD/Dialysis, morbid obesity, at risk of malnutrition due to comorbidities. The interventions included, but not limited to, initiated 8/14/25 Prosource No CHO (no carbohydrate) BID (twice a day) and initiated 8/20/25 Nepro supplement BID. Additionally, a focus area initiated 8/13/25 I have Diabetes Mellitus-Type and Type 2 DM with complications. The interventions included, but not limited to, Diabetes medication as ordered. And Monitor glucose as ordered. A review of the resident's Order Summary Report (OSR) had no physician's order (PO) indicating the hemodialysis days or times. A review of the electronic nursing progress notes (EPN) revealed the resident's dialysis days were Tuesday, Thursday and Saturday with a pickup time of 1:00 PM and chair time of 2:00 PM. Further review of the OSR revealed the following POs that indicated times of administration that would coincide with the resident being out to dialysis: Hydralazine HCl (hydrochloride) Oral Tablet 100 MG (Hydralazine HCl) Give 1 tablet by mouth every 8 hours for hypertension. Check patient's B/P and HR before giving Hydralazine. With Start Date of 8/13/25. Novolog PenFill Subcutaneous Solution Cartridge 100 Unit/ML (milliliter) (Insulin Aspart) Inject 3 unit subcutaneously before meals for DM. with a Start Date of 8/14/25. Blood Glucose Monitoring before meals and at HS (bedtime) before meals and at bedtime for signs /symptoms of hyper/hypoglycemia Call MD/NP for Blood Sugars less than 60 or greater than 400. With an Start Date of 8/14/25. Prosource No Carb two times a day for low albumin/dialysis. With a Start Date of 8/14/25.Nepro two times a day for dialysis. with a Start Date of 8/20/25. Carvedilol (Coreg) Oral Tablet 25 MG (milligrams) (Carvedilol) Give 1 tablet by mouth two times a day for hypertension. Hold for systolic BP (blood pressure)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # NJ2666691 Based on observations, interviews, record review, and pertinent facility documents it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents a.) conducted face-to-face visits and wrote progress notes at least every thirty days for the first ninety days of admission and b.) were seen by the attending physician or Nurse Practitioner (NP) every thirty days with a physician visit at least every sixty days. This deficient practice was observed for 4 of 4 residents (Resident #2, #6, #10, and #125) reviewed for physician visits.This deficient practice was evidenced by the following:1.On 11/20/25 at 10:57 AM, the surveyor observed Resident #10 sitting in their chair with their eyes closed. The surveyor reviewed the Electronic Medical Record (EMR) for Resident #10.A review of the admission Record (AR) revealed the resident was admitted to the facility with diagnoses which included but not limited to: Type 2 Diabetes Mellitus (a condition that causes blood sugar to rise), difficulty with walking and Asthma (a lung disease that makes it harder to move air in and out of the lungs)A review of the Quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care dated 10/09/25, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 5 out 10, which indicated the resident was severely cognitively impaired. A review of the EMR did not reveal a Progress Notes (PN) from the attending physician from January 2025 through October 2025. On 11/25/25 at 12:22 PM, during an interview with the surveyor, the Licensed Practical Nurse/Unit Manager (LPN/UM#1) stated for Long Term Care (LTC) residents, the attending physicians and the Nurse Practitioner (NP) would make rounds at least once a month. For newly admitted residents, the LPN/UM #1 stated she was not sure how soon the attending physician would come see the resident. The surveyor inquired about Resident #10's attending physician visit notes. LPN/UM #1 stated Resident #10 should have a PN from the NP and the attending physician. LPN/UM #1 stated the expectation from the attending physician was to document when they made their rounds at the facility. LPN/UM #1 reviewed Resident #10's EMR in the presence of the surveyor and confirmed there were no PN by the attending from January -October.2.On 11/20/25 at 11:18 AM, the surveyor observed Resident #6 lying in bed with their eyes closed. The resident had their call bell within reach.The surveyor reviewed the EMR for Resident #6. A review of the AR revealed the resident was admitted to the facility with diagnoses which included but not limited to: Hyperlipidemia (high lipids), pain in right and left foot.A review of the MDS, dated [DATE], revealed the resident had a BIMS score of 5 out of 15, which indicated the resident was severely cognitively impaired. A review of the EMR did not reveal a History and Physical note (H&P- a comprehensive assessment note completed by physician on admission) from the initial admission and re-admission in September 2025, or a PN from the attending physician from August 2025-October 2025.On 11/25/25 at 12:27 PM, the surveyor inquired about Resident #6's H&P and physician visit notes. LPN/UM #1 reviewed Resident #6's EMR in the presence of the surveyor and confirmed there were no physician notes and/or H&P for the resident. LPN/UM #1 stated Resident #6 was hospitalized for five (5) days in September 2025 and further stated the expectation was when the resident was re-admitted at the facility, the physician should have completed H&P.3.On 11/21/25 at 10:09 AM, the surveyor observed Resident #2 eating breakfast in their bed. The surveyor reviewed the Electronic Medical Record (EMR) for Resident #2. A review of the AR revealed the resident was admitted to the facility with diagnoses which included but not limited to: Low back pain and Anemia. A review of the MDS, dated [DATE], revealed Resident #2 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact.A review of the EMR revealed an attending physician H&P note dated 12/21/24 and another PN dated 2/18/2025. Further review of the PN reflected PN from the NP dated 1/6/25, 1/7/25, 1/9/25, 1/14/25, 1/16/25, 1/17/25, 1/20/25, 1/23/25, 1/24/25, 1/28/25, 1/31/25, 2/2/25, 2/3/25, 2/12/25, 2/17/25, 2/121/25, 2/27/25, 3/5/25, 3/6/25, 3/10/25, 3/14/25, 3/17/25, 3/24/25, 9/5/25, 9/30/25, 10/28/25, 10/30/25, 11/6/25, 11/18/25, 11/20/25, 11/21/25, 11/26/25. A review of the EMR did not reveal a PN from the attending physician or the NP in April 2025, May 2025, June 2025, July 2025, August 2025 or that the physician and the NP were consistently alternating monthly visits.On 11/26/25 at 11:24 AM, during an interview with the surveyor, LPN/UM #1 stated when the resident was admitted or re-admitted , the physician should come to see them within 48 hours to review hospital records, orders, any labs, follow up appointments and document a H&P. LPN/UM #1 further stated when the physician made their rounds, they should be putting a note in the EMR[name redacted] with a change in the plan of care. LPN/UM #1 further stated documentation was important for communication so