STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315223	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 Based on interview, record review, and facility policy review, the facility failed to accurately complete Medicare Part A form Centers for Medicaid and Medicare Services (CMS)-10123 Notice of Medicare Non-Coverage (NOMNC) for one of three residents (Resident (R) 6) and accurately complete CMS Skilled Facility Nursing Advanced Beneficiary (SNFABN) CMS-10055 form for two of three residents (R6 and R79) reviewed for beneficiary notices of 29 sample residents. The forms were used to notify Medicare Part A beneficiaries when their skilled therapy or skilled nursing services were ending. Findings include: 1. Review of the Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted on [DATE]. Review of the NOMNC provided by the facility and issued to R6 with a last covered day of 03/08/24, revealed it did not contain the TTY (teletypewriter phone number) a service for the hard of hearing or deaf to assist them in filing an appeal. The form was also missing the name of the Quality Improvement Organization (QIO.) The QIO was the group responsible for reviewing the information for an appeal. Review of the SNFABN issued by phone on 03/08/24 and provided by the facility, revealed it did not have the facility telephone number as required. In the box labeled care the facility entered skilled nursing care. The second box identified the reason Medicare may not pay was written Therapy goals have been met and in the last box labeled cost the Business Office Manager (BOM) had entered available income. R6 was receiving Medicare A services, and she was going to return to Medicaid as her primary payment status. 2. Review of the Admission Record located in the EMR under the Profile tab, revealed the resident was admitted on [DATE]. Review of R79's SNFABN issued by phone on 03/27/24 and provided by the facility, revealed it had been completed in the same manner. The facility phone number was not on the form. The box labeled care was completed with skilled nursing care. The box labeled Reason Medicare Might Not Pay was documented as therapy goals have been met and Cost was completed with available income. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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: 315223	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER: Avalon Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1059 Edinburg Road Hamilton, NJ 08690	

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Medicare Advance Beneficiary and Medicare Non-Coverage Notices, last revised 09/22, revealed there were no instructions on how to complete either form. Review of the 2018 instructions titled, Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 revealed, .The first blank above the title.The SNF must include the SNF's name, address, and phone number at a minimum. In section B .The description must be written in plain language that the beneficiary can understand . In the section titled Reason May Not Pay, the directions stated, .The SNF must give the applicable Medicare coverage guideline(s) . In the Cost box the facility should enter an estimated total cost or a daily, per item, or per services . Review of the undated Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 revealed, .Insert the name and telephone numbers (including TTY) of the applicable QIO in no less than 12-point type. NJAC 8:39-5.1(a)

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Note: The nursing home is disputing this citation.

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 25232

Based on interviews, record review, and review of facility policy, the facility failed to ensure residents were free from abuse for one (1) of five (5) residents (Resident #13) reviewed for abuse. In addition, this failure has the potential to affect 143 other residents residing in the facility who were not protected from the alleged perpetrator.

The facility's failure to ensure all residents were free from abuse, by not investigating an allegation of abuse reported by Resident #13 posed a likelihood of serious harm to Resident #13 and all residents. This resulted in an Immediate Jeopardy (IJ) situation.

On 06/11/24 at 9:50 PM, the Administrator and Director of Nursing (DON) were notified that the failure to identify and protect one resident from alleged abuse which constituted an Immediate Jeopardy to the health and safety of all residents in the facility at F 600: Free from Abuse and Neglect. The Immediate Jeopardy began on 01/05/24, when Resident #13 reported that Certified Nursing Assistant (CNA #1) pushed him/her.

The facility provided an Immediate Jeopardy Removal Plan that was accepted on 06/12/24 at 8:24 PM. The survey team verified the implementation of the removal plan through staff interviews, and review of facility training. The Immediate Jeopardy was removed on 06/13/24 at 6:30 PM.

Findings include:

Review of Resident #13's undated Admission Record, provided by the facility, indicated that Resident #13 was readmitted to the facility on [DATE], with diagnoses of diabetes mellitus, chronic pain syndrome, and personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits.

Review of the Progress Notes, provided by the facility and dated 01/05/24, revealed, "At around 9:00 PM, heard [Resident #13] yelling at a CNA .When approached, [Resident #13] stated .[CNA #1] pushed [Resident #13] out of the way making the hot coffee spill .pantry floor was wet with coffee and [Resident #13's] lap was a little wet .Both hands were checked, but are dry and skin normal temperature. [Resident #13] claims that hands and lap feel tingling .Further skin assessment made. No apparent injury."

(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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Full Quality Assurance (QA) Report'' provided by the facility and dated 01/05/24, revealed '' . first degree burn .pelvic area .according to [Resident #13], tingling sensation on lap (close to groin area), [Resident #13's] skin was normal temperature, normal to touch, no redness, no flaking or scales . preventative/protective skin care, cold compress for five minutes .Conclusion: . [Resident #13] stated 'the hot coffee fell on me.' Upon .interviewing [Resident #13] and the [Certified Nursing Assistant (CNA #1)], coffee indeed was noted to spill on [Resident #13's] lap . [CNA #1] was attempting to get fresh ice water for her residents, while [Resident #13] was warming up their coffee. [Resident #13] became angry with [CNA #1] for being in the nourishment room at the same time [Resident #13] was in there. As [CNA #1] attempted to leave the nourishment room, [Resident #13] positioned themselves blocking the entranceway and threatening [CNA #1]. [Resident #13] would pour coffee on her as [Resident #13] stood up from the wheelchair. In the process of [CNA #1] trying to get pass [Resident #13] so [Resident #13] would not pour coffee on her, [Resident #13] spilled a small amount of coffee on themselves. [Resident #13] reported that [CNA #1] physically pushed [Resident #13]. Review of the QA Investigative Statements: (Typed written statement by [Licensed Practical Nurse (LPN #3)] revealed, .[Resident #13] was heard in the hall yelling at a [CNA #1], very upset .[Resident #13] stated that the [CNA #1] pushed [him/her] out of the way making the coffee spill on [Resident #13] and walked away . immediately inspected the surroundings and noted coffee spill on the floor. Checked [Resident #13] and noted smell of coffee lingers on [Resident #13] and lap was a little wet with coffee .Coffee spills was wiped off the floor .[Resident #13] stated tingling sensation on both lap closer to groin. Further review of the QA report revealed a typed written statement documented by [Resident #13]) .that aide [CNA #1] pushed me and made me spill my coffee on me.'' Review of facility provided, undated and untitled handwritten document by CNA #1, revealed ''On 01/05/24 at about 4:00 PM, I was entering the nutrition room to get ice for my residents. [Resident #13] was already in there heating up their meal. [Resident #13] was sitting near the sink. I asked [him/her] to let me get to sink to pour out water. [Resident #13]replied why every time I am in here, you come to disturb me . [Resident #13] continued to curse at me as [he/she] sat back down in the wheelchair. So I left the room to pass ice water. As I returned to get more ice water, [Resident #13] was still using the microwave. I asked [Resident #13] to excuse me again, [Resident #13] replied, I have killed 100 persons-I will kill you . As I was attempting to leave out of the nutrition room [Resident #13] positioned themselves blocking the doorway with the coffee container in [Resident #13's] hand. [Resident #13] was carrying a basin was in their lap. [Resident #13] said to me, I will burn you . I became afraid, and I squeezed past [Resident #13] to get out of [Resident #13's] way.'' (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 06/11/24 at 3:15 PM, the surveyor interviewed CNA #1 who confirmed during the incident on 01/05/24, Resident #13 was in the ice room using the microwave, which was on the counter next to the medication room, when she went in there for a cup of ice for one of her 600-hall residents. She stated Resident #13 started yelling at her, asking her why she was in here and said that she was not to be in here when [Resident #13] was in here. She stated she took the cup of ice and left the room without speaking with Resident #13. She then stated that Resident #13 stood up, and threatened to slap her if she did not get out of the room. CNA #1 stated [Resident #13] threatened to beat her up after cursing her out. She stated Resident #13 sat back down in the wheelchair, and this was when she took her ice and left the room. She stated she was only in the nutritional room one time, denied going back for a second time, as her written statement indicated. CNA #1 further stated that she went back to her hall and started doing rounds after exiting the nutrition room. CNA #1 indicated that the nurse [LPN #4] told her that the supervisor [LPN #1], who was not at the facility during this incident, wanted her to write a statement because Resident #13 accused her of burning Resident #13. Then CNA #1 stated because she burned him, pushed [Resident #13] or something like that. CNA #1 stated after she wrote her written statement, she gave it to LPN #1 and confirmed that she was not asked to leave the facility. She stated she wrote Resident #13 was heating coffee in the microwave and had nothing in their hands while speaking with her. CNA #1 indicated that the next day, she was asked to come to the facility in the morning and spoke with the Director of Nursing (DON) and LPN #1. She indicated they asked her what happened, and she said that Resident #13 was warming their coffee, while she got ice, and she left the nutritional room, while Resident #13 remained in the room. CNA #1 confirmed that Resident #13 was sitting near the opened door when she passed Resident #13 and went onto the floor. On 06/11/24 at 7:10 PM, the surveyor interviewed the DON who stated even if the incident happened today, the facility would have suspended CNA #1, but allow CNA #1 to return to work because CNA #1 was not in the room with Resident #13 and Resident #13 made things up. The DON confirmed that when the QA report was completed, it was reviewed the next business day during the morning meeting. The DON stated after completing the QA report, it triggered an email to management and corporate, which generated follow up emails as to what happened. She stated she was told by LPN #3, LPN #4, and CNA #1, that CNA #1 was not in the nutrition room when Resident #13 spilled coffee on themselves. After the DON reviewed the statements, where Resident #13 reported physical abuse by CNA #1, the DON confirmed that this should have been reported within two hours of the staff's knowledge, and that CNA #1 should have been suspended. On that same date at 7:37 PM, after re-reading the abuse policy, the DON stated she would re-open this investigation and report. She stated CNA #1 would have been suspended immediately and confirmed that she dropped the ball. During a follow up interview at 8:32 PM, she confirmed that CNA #1 had been suspended and that the staff currently in the building had been in-serviced on abuse. She stated the state agency (SA) and police had been notified. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 06/12/24 at 11:00 AM, the surveyor interviewed Resident #13 who stated the 01/05/24 incident occurred while [Resident #13] was heating up food in the microwave. Resident #13 confirmed CNA #1 came into the nutritional room, where [Resident #13] was sitting by the ice machine, and CNA #1 pushed past [Resident #13]. Resident #13 stated that [he/she] told CNA #1, At least you can say excuse me. Resident #13 confirmed that CNA #1 said something, but [he/she] could not understand her, and CNA #1 left the nutritional room. Resident #13 indicated that [he/she] finished warming up their food, and coffee. Resident #13 further stated [he/she] had taken the coffee out of the microwave, had it in [his/her] right hand, and was getting ready to go out of the nutritional room, and was near the ice machine. Resident #13 stated CNA #1 entered the nutritional room, pushed past [him/her] on the right side to go to the sink, causing the hot coffee to spill on [Resident #13]. Resident #13 stated [he/she] started yelling and verbally threatening CNA #1 and CNA #1 did not stop and walked out of the nutritional room. Resident #13 stated when CNA #1 went out of the nutritional room, she went straight to the LPN #4 on the 600-hall, where Resident #13 heard CNA #1 telling the LPN #4 what happened and laughing about it. Resident #13 further stated LPN #3 came to find out what was wrong. Resident #13 stated [he/she] told LPN #3 that CNA #1 pushed [Resident #13] causing the hot coffee to spill on [Resident #13] legs. Resident #13 stated a day later, LPN #1 came and spoke with [him/her] about the incident. Resident #13 confirmed that [he/she] told LPN #1 that CNA #1 pushed [Resident #13] causing the coffee to spill on [Resident #13]. Resident #13 stated LPN #1 told [him/her] that CNA #1 was not to be around [Resident #13] anymore. Resident #13 stated that the same day [he/she] spoke with LPN #1 and CNA #1. On 06/12/24 at 2:40 PM, the surveyor interviewed LPN #1 who stated she spoke with Resident #13 following the 01/05/24 incident. She confirmed Resident #13 told her that CNA #1 pushed [Resident #13] and that Resident #13 was able to identify CNA #1 by name. She indicated she would not classify Resident #13's statement to be abuse and indicated that Resident #13 was both verbally and physically threatening towards CNA #1, making CNA #1 afraid. The LPN #1 stated CNA #1 may have accidentally hit Resident #13's wheelchair when exiting the nutritional room. Review of Resident #13's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/04/23, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated Resident #13 was cognitively intact and able to make themselves understood and understand others. Review of facility provided CNA #1's "Regular Monthly Schedule," provided by the facility for January 2024, revealed evidence that CNA #1 worked the following dates: 01/05/24, 01/06/24, 01/07/24, 01/09/24, 01/10/24, 01/11/24, 01/12/24, 01/15/24, 01/16/24, 01/17/24, 01/19/24, 01/20/24, 01/21/24, 01/23/24, 01/25/24, 01/26/24, 01/29/24, 01/30/24, and 01/31/24. This schedule showed that CNA #1 worked for 19 days after the allegation of physical abuse occurred. Review of facility policy titled, "Abuse, Neglect, Exploitation and Misappropriation Prevention Program," dated 10/22, revealed "Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to .physical abuse. Policy Interpretation and Implementation: The resident abuse, neglect and exploitation program consist of a facility-wide commitment and resource to support the following objectives: 1. Protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff .9. Identify .all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property." (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	An acceptable Removal Plan on 06/12/24 at 8:24 PM indicated the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including suspending CNA #1 pending investigation, notifying the New Jersey Department of Health of the allegation of abuse, and educating all staff on the facility abuse policy. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 06/13/24. NJAC 8:39-4.1(a)5 NJAC 8:39-9.4(f) NJAC 8:39-13.4(c)2

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on record review, interviews and policy review, the facility failed to ensure an incident of alleged physical abuse by one of five residents (Resident (R) 13) reviewed for abuse out of 29 sampled residents was reported to the state agency (SA) within two hours of knowledge of the alleged physical abuse. This failure placed R13 at risk for serious injury, serious harm, serious impairment, and/or death. Findings include: Review of R13's undated "Admission Record" provided by the facility, indicated R13 was readmitted to the facility on [DATE] with diagnoses of diabetes mellitus, chronic pain syndrome, and personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits. Review of R13's quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/04/23, revealed a "Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact. He was able to make himself understood and understand others. Review of facility provided " Full Quality Assurance (QA) Report," dated 01/05/24, revealed " .Conclusion: . [R13] stated The hot coffee fell on me. Upon investigation and interviewing of [R13] and Certified Nursing Assistant [CNA1], coffee indeed was noted to spill on his lap . [CNA1] was attempting to get fresh ice water for her residents, while [R13] was warming up his coffee. [R13] became angry with [CNA1] for being in the nourishment room at the same time he was in there. As [CNA1] attempted to leave the nourishment room, [R13] positioned himself blocking entranceway threatening [CNA1] he would pour coffee on her as he stood up from his chair. In the process of [CNA1] trying to get pass [R13] so he would not pour coffee on her, [R13] spilled small amount of coffee on himself. [R13] reported that [CNA1] pushed him .Investigative Statements: [Typed written statement by Licensed Practical Nurse (LPN) 3] .[R13] was heard in the hall yelling at a CNA [meaning CNA1], very upset .[R13] stated that the CNA [meaning CNA1] pushed him out of the way making the coffee spill on him and walked away .immediately inspected the surroundings and noted coffee spill on the floor. Checked [R13] and noted smell of coffee lingers on him and lap was a little wet with coffee .Coffee spills was wiped off the floor .[R13] stated tingling sensation on both lap closer to groin." During further review revealed " . [Typed written statement of R13] .that aide pushed me and made me spill my coffee on me." During an interview on 06/10/24 at 6:45 PM, the Regional Director of Operations confirmed that neither the SA and/or Ombudsman were notified regarding the 01/05/24 incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/24 at 12:10 PM, the Director of Nursing (DON) indicated that this incident was not reported to the SA. The DON stated that if the staff investigating the incident could conclude, the SA would not be notified. However, if the staff investigating could not conclude, then the incident would be reported to the SA. The DON confirmed that LPN3 witnessed the incident and felt no need to go any further because CNA1 was not right there when R13 spilled coffee on himself. At 7:10 PM, after the surveyor showed her the statements where R13 reported alleged physical abuse by CNA1, she indicated that this should have been reported within two hours of staff's knowledge, and that CNA1 should have been suspended pending investigation. During an interview on 06/11/24 at 8:06 PM, the Administrator indicated this alleged abuse was not reported to the SA. Review of the facility's policy titled, "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating," revised 09/22, revealed, "All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) .Policy Interpretation and Implementation: Reporting Allegations to the Administrator and Authorities: 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law. 2. Upon 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. 3. Immediately is defined as: a. within two hours of an allegation abuse or result in serious bodily injury." NJAC8:39-9.4(f)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on record review, interviews and facility policy review, the facility failed to ensure an incident of alleged physical abuse was thoroughly investigated for one of five residents (Resident (R) 13) reviewed for abuse of 29 sampled residents This failure placed R13 at risk for serious injury, serious harm, serious impairment, and/or death. Findings include: Review of R13's undated "Admission Record" and provided by the facility, indicated R13 was readmitted to the facility on [DATE] with diagnoses of diabetes mellitus, chronic pain syndrome, and personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits. Review of R13's quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/04/23, revealed a "Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact. He was able to make himself understood and understood others. Review of the " Full Quality Assurance (QA) Report" and provided by the facility, dated 01/05/24, revealed " . Conclusion: . [R13] stated the hot coffee fell on me. Upon investigation and interviewing of [R13] and Certified Nursing Assistant [CNA1], coffee indeed was noted to spill on his lap . [CNA1] was attempting to get fresh ice water for her residents, while [R13] was warming up his coffee. [R13] became angry with [CNA1] for being in the nourishment room at the same time he was in there. As [CNA1] attempted to leave the nourishment room, [R13] positioned himself blocking entranceway threatening [CNA1] he would pour coffee on her as he stood up from his chair. In the process of [CNA1] trying to get pass [R13] so he would not pour coffee on her, [R13] spilled small amount of coffee on himself. [R13] reported that [CNA1] pushed him . Investigative Statements: [Typed written statement by Licensed Practical Nurse (LPN) 3] .[R13] was heard in the hall yelling at a CNA [meaning CNA1], very upset .[R13] stated that the CNA [meaning CNA1] pushed him out of the way making the coffee spill on him and walked away .immediately inspected the surroundings and noted coffee spill on the floor. Checked [R13] and noted smell of coffee lingers on him and lap was a little wet with coffee .Coffee spills was wiped off the floor .[R13] stated tingling sensation on both lap closer to groin." During further review revealed " . [Typed written statement of R13] .that aide pushed me and made me spill my coffee on me." No evidence of other interviews conducted with this paperwork. Review of facility provided, undated and untitled handwritten document by CNA1 revealed "On 01/05/24 at about 4:00 PM, I was entering the nutrition room to get ice for my residents. [R13] was already in there heating up his meal. He was sitting near the sink. I asked him to let me get to sink to pour out water. He replied why every time I am in here, you come to disturb me . He continued to curse at me as he sat back down in his wheelchair. So, I left the room to pass ice water. As I returned to get more ice water, he was still using the microwave. I asked him to excuse me again, he replied I have killed 100 persons-I will kill you . As I was attempting to leave out of the nutrition room [R13] positioned himself blocking the doorway with his coffee container in his hand, his carrying basin was in his lap. He said to me I will burn you . I became afraid, and I squeezed past him to get out of his way." (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/24 at 3:15 PM, CNA1 confirmed during the incident on 01/05/24, R13 was in the ice room using the microwave, which was on the counter next to the medication room, when she went in there for a cup of ice for one of her 600-hall residents. She stated that R13 started yelling at her, asking her why she was in here and said that she was not to be in here when he was in here. She said that she took the cup of ice and left the room without speaking with R13. She then said that R13 stood up, and threatened to slap her if she did not get out of the room. CNA1 stated he threatened to beat her up after he cursed her out. She stated that R13 sat back down in his wheelchair, and this was when she took her ice and left the room. She stated she was only in the nutritional room one time, denied going back for a second time, as her written statement indicated. CNA1 stated she went back to her hall and started doing rounds after exiting the nutrition room. CNA1 indicated that the nurse [LPN4] told her that the supervisor [LPN1], who was not at the facility during this incident, wanted her to write a statement because R13 accused her of burning him. Then CNA1 stated because she burned him, pushed him or something like that. She stated after she wrote her written statement, she gave it to LPN1 and confirmed that she was not asked to leave the facility. CNA1 stated she wrote R13 was heating coffee in the microwave and had nothing in his hands while speaking with her. CNA1 indicated that the next day, she was asked to come to the facility in the morning and spoke with the Director of Nursing (DON) and LPN1. She indicated they asked her what happened, and she said R13 was warming his coffee, while she got ice, and she left out of the nutritional room, while R13 remained in the room. CNA1 confirmed R13 was sitting near the opened door when she passed him and went onto the floor. During an interview on 06/12/24 at 11:00 AM, R13 stated the 01/05/24 incident occurred while he was heating up his food in the microwave. He confirmed [CNA1] who wears a scarf on her head every day, came into the nutritional room, where he was sitting by the ice machine, and the aide [CNA1] pushed past him. R13 stated he told the aide, At least you can say excuse me. R13 confirmed that the aide said something, but he could not understand her, and the aide [CNA1] left the nutritional room. R13 indicated that he finished warming up his food, and coffee. He stated he had taken the coffee out of the microwave, had it in his right hand, and was getting ready to go out of the nutritional room, putting him near the ice machine, when the aide [CNA1] entered the nutritional room, pushed past him on his right side, to go to the sink, causing his hot coffee to spill on him. He stated that was when he was yelling and threatening to beat the aide's [CNA1] ass, while the aide did not stop and walked right out the nutritional room's door. He stated when the aide [CNA1] went out of the nutritional room, she went straight for the nurse on the 600-hall, where he heard the aide [CNA1] telling the nurse what happened and laughing about it. At this point, he stated his nurse [LPN3] came to find out what was wrong. After telling LPN3 that the aide [CNA1] pushed him causing his hot coffee to spill on his legs, R13 stated a day later LPN1 came and spoke with him about the incident. R13 confirmed that he told LPN1 that the aide [CNA1] pushed him causing his coffee to spill on himself. He stated LPN1 told him that the aide [CNA1] was not to be around him anymore. R13 stated that the same day he spoke with LPN1, the aide [CNA1] was seen in the facility, and she went into the nutritional room at the same time the resident was in the room, causing R13 to tell the aide [CNA1] that she was not allowed in there while he was in there. R13 stated that the aide [CNA1] said something in a broken language he did not understand, and she left the nutritional room without saying anything to him. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/24 at 12:10 PM, the Director of Nursing (DON) confirmed that CNA1, LPN3, LPN4, and R13 were all there in the hall. She indicated LPN3 witnessed the incident and felt no need to go any further with the investigation because CNA1 was not in the nutritional room when R13 spilled his coffee. During a further interview at 7:10 PM, she stated that even if the incident happened today, CNA1 would be suspended, but the facility would have brought her back because R13 tended to make things up. At 7:37 PM, she confirmed that she dropped the ball and was restarting an investigation into this incident. During an interview on 06/11/24 at 8:06 PM, the Administrator indicated that he agreed with DON's acknowledgement about re-opening the incident and following through with the facility process. During an interview on 06/12/24 at 2:40 PM, LPN1 indicated that she spoke with R13 the week after the 01/05/24 incident. She confirmed that R13 told her CNA1 pushed him. She stated R13 was able to identify CNA1 by name. LPN1 confirmed CNA1 called her, and CNA1 was told to write what happened on paper and slide under her office door. She indicated that she did not believe that CNA1 was sent home; however, Registered Nurse (RN) 2 was the evening supervisor and believed she was aware of the incident. She indicated that she would not classify R13's statement as abuse and indicated that R13 was both verbally and physically threatening to CNA1, making CNA1 afraid. LPN1 stated CNA1 may have accidentally hit R13's wheelchair when exiting the nutritional room. She claimed that CNA1 was out of the nutritional room by the time R13 was yelling about his coffee being spilled. During another interview at 4:09 PM, she stated that during investigation of an alleged allegation, she would have taken statements from the resident, staff and/or witnesses involved, along with reviewing any documentation prior to writing a conclusion of the incident. The LPN1 was unable to provide any additional documentation regarding this incident. Review of the facility "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating" policy, revised 09/22, revealed, "All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are . thoroughly investigated by facility management . Policy Interpretation and Implementation. Reporting Allegations to the Administrator and Authorities .Investigating Allegations: 1. All allegations are thoroughly investigated. The Administrator initiates investigations. 2. Investigations may be assigned to an individual trained in reviewing, investigating and reporting such allegations .The Administrator ensures that the resident and the person(s) reporting the suspected violation is protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. 5. The individual conducting the investigation as a minimum: a. reviews the documentation and evidence .d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative .h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident .j. interviews other residents to whom the accused employee provides care or services; k. reviews all events leading up to the alleged incident; and l. documents the investigation completely and thoroughly." NJAC 8:39-9.4(f)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39411 Based on record review, interview, and policy review, the facility failed to ensure the Pre-Admission Screen and Resident Review (PASARR) level one screen was completed correctly prior to admission for one of one resident (Resident (R) 112) reviewed for PASARR of 29 sampled residents. This created a potential failure to identify what specialized or rehabilitative services the resident needed and whether placement in the facility was appropriate prior to admission. Findings include: Review of R112's Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses of schizoaffective disorder. Review of R112's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/05/24 and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderately impaired cognition. R112 was admitted from the hospital. Review of the Orders tab of R112's EMR revealed the following psychotropic medication order: Thiothixene (an antipsychotic to treat schizophrenia), two milligrams (mg) daily, which originated on 11/29/23. Review of R112's Pre-Admission Screening and Resident Review [PASARR] Level I Screen, dated 08/30/23 and located in the EMR under the Miscellaneous tab, revealed it was submitted by the hospital Case Worker to the facility upon R112's admission. The form indicated in Section Two-Mental Illness Screen R112 did not have a diagnose or evidence of a major mental illness disorder. During an interview on 06/12/24 at 3:48 PM, the Social Services Director (SSD) stated the hospital had filled out the PASARR and filled out Section II incorrectly. She stated that that R112 had the diagnosis of schizophrenia for many years and the correct answer should have been yes. The SSD stated they were responsible for making sure the form was filled out correctly. Review of the facility's policy titled, Admission Criteria, dated March 2019, revealed Our facility admits only residents whose medical and nursing care needs can be met .All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. NJAC8:39-5.1(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on interview, record review, and review of facility policy, the facility failed to ensure that an activity care plan was developed for one of 29 sampled residents (Resident (R) 49) that included the preference for one-to-one activities. This failure had the potential to cause the resident to experience increased depression. Findings include: Review of R49's Admission Record located in the resident's electronic medical records (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses that included aftercare for hip replacement surgery; hemiplegia, hemiparesis affecting left side; major depressive disorder, seizures, and cerebral infarct. Review of R49's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/13/24 located in the resident's EMR under the MDS tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident was cognitively intact. The resident was dependent on staff for all activities of daily living (ADL); the resident had impairment of the left upper extremity and impairment of both lower extremities. The resident was coded to receive antidepressant daily and opioids. Review of R49's Physician Orders, dated 04/09/24, located in the resident's EMR under the Orders tab, revealed the resident was to receive Fluoxetine for depression; Oxycodone for chronic pain; Trazadone for depression. On 06/11/24, R49's Fluoxetine was increased to 60 milligrams at bedtime. Review of R49's Admission Activities Assessment, dated 04/17/23, located in the resident's EMR under the Evaluations tab, revealed the resident enjoyed watching the news, sports, reading, music, and church. It was documented in the assessment that the resident did not wish to participate in group activities but would like to have one-to-one activities with the staff. Review of R49's Care Plan, initiated 04/09/24, located in the resident's EMR under the Care Plans tab, did not reflect the resident's desire for one-to-one activities nor the care plan to address providing activities that the resident liked. During an interview on 06/11/24 at 12:14 PM, Licensed Practical Nurse (LPN) 1 revealed the resident had diagnosis of major depressive disorder. LPN1 stated the resident was to see the psychologist this day. LPN1 stated the resident did not like to participate in group activities and preferred to stay in his room. LPN1 was unsure if the resident was on the list for one-to-one visits from activities. LPN1 reviewed R49's and was unable to find an activity care plan. LPN1 stated the Activities Director was responsible for completing the activities care plans for the residents. During an interview on 06/13/24 at 1:10 PM, the Activity Director (AD) stated she was familiar with R49's diagnosis of major depressive disorder and that sometimes the resident would attend activities outside his room. The AD stated that she was new to the position and was unsure if the resident had a care plan developed for activities. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an additional interview on 06/13/24 at 1:45 PM, the AD stated she completed the admission activities assessment but did not develop a care plan which reflected the resident's desires to have one-to-one activities. Review of the facility's policy titled, Care Plans, Comprehensive Person Centered with revision date of March 2022, revealed the document read in part .The comprehensive person-centered care plan describes services that are to be furnished to attain or maintain the resident highest practicable physical, mental, and psychosocial we-being . NJAC8:39-11.2(e) thru (i) NJAC8:39-27.1(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on interview, record review, and facility policy review, the facility failed to ensure that the care plan was revised to reflect a sustained coffee burn for one of two residents (Resident (R) 40) reviewed for accident hazards of 29 sample residents. This failure had the potential to affect resident safety resulting in potential reoccurrence of coffee burns. Findings include: Review of R40's Admission Record located in the resident electronic medical records (EMR) under the Profile tab, revealed the resident was initially admitted on [DATE] with diagnoses that included diabetes mellitus type II, depression, acute kidney failure, transient ischemic attacks, and cerebral infarct. Review of the facility's accident/incident log for 2023-2024 and provided by the facility, revealed R40 sustained coffee burns while attempting to transport coffee from dining room to his room sustained second degree burn to the right thigh/hip areas. Review of the facility's investigation, dated 11/01/23 and provided by the facility, revealed R40 sustained a second degree burn while attempting to transport a cup of hot coffee from the dining room to his wheelchair. The facility developed the following interventions to prevent a reoccurrence of this type of incident. completed pain assessment, frequent skin checks, and treatments as ordered. Educated the resident to ask for assistance for carrying hot items to his room and not to attempt wheeling himself and trying to carry items at the same time. Staff education to make sure coffee was cooled before offering it to the residents. Review of R40's Care Plan with most revision date of 05/10/14 and located in the resident's EMR under the Care Plan tab, failed to reveal the resident's care plan was revised/ updated to reflect the incident with the hot coffee; reminding the resident to ask for assistance when carrying hot items to his room; and the staff education to let hot liquids cool before offering to the resident. During an interview on 06/10/24 at 5:15 PM, Licensed Practical Nurse (LPN) 2 stated that she helped with the investigation of the incident. LPN2 stated to ensure there was not a repeat of the incident, the resident was reminded to ask for assistance when transporting hot items to his room and not carry such items in his wheelchair. LPN2 stated the staff (including dietary and nursing) were educated to let the hot liquids cool before giving it to the resident. She stated residents served coffee in their rooms would have a lid over the coffee cup to prevent spillage. LPN2 also stated the resident's care plan should have been revised to reflect the problem and interventions in place. LPN2 reviewed the care plan and acknowledged the care plan was not revised. During an interview on 06/14/24 at 1:30 PM, the Director of Nursing (DON) stated any nurse could revise a resident's care plan to reflect any changes in the condition and new interventions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Care Plans, Comprehensive Person Centered, revised March 2022, read in part .Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition changes . NJAC 8:39-11.2(e),(f),(h)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39411 Based on record review, interview, and facility policy review, the facility failed to provide quality care in accordance with physician orders for one of one resident (Resident (R) 78) of 29 sample residents. Specifically, the facility failed to weigh R78 as ordered. This placed R78 at risk for an unmonitored weight loss. Findings include: Review of the undated Admission Record located in the electronic medical record (EMR) under the Profile tab, indicated R78 was admitted to the facility on [DATE] with diagnoses which included anoxic brain injury, muscle wasting, type II diabetes mellitus, dysphasia, and altered mental state. Review of R78's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/07/24 and located in the MDS tab of the EMR, revealed R78 had a feeding tube (TF) which provided 51% or more of daily total calories. R78's weight was documented as 190 pounds (lbs.) upon admission. Review of the care plan located in the EMR under the Care Plan tab, revealed a focus area, dated 04/11/24, of unplanned weight loss related to recent hospitalization . The documented goal was a stable weight of 169. Interventions included notifying the physician and the Registered Dietitian (RD) if weight loss persisted and to obtain weights as ordered. Review of R78's Order Summary Report located in the EMR under the Order tab, revealed an order, dated 04/03/24, for weekly weights for four weeks then monthly weights once a week. The order indicated the start date was 04/10/24. Review of the Weight and Vitals Summary, dated 04/10/24 and located in the EMR under the Weights and Vitals tab, revealed R78 weighed 169.4 lbs. (sitting weight) indicating a 10.84% weight loss in six days. Review of the Nutrition notes, dated 04/11/24 and located in the EMR under the Progress Notes tab, revealed R78 had an 11% weight loss since admission. The Nutrition note indicated R78's TF was adjusted to increase calories. Review of the Nutrition notes, dated 04/25/24 and located in the EMR under the Progress Notes tab, revealed R78's weight was 186.8 indicating a 22.4% increase in 14 days. Review of the Nutrition notes, dated 04/29/24 and located in the EMR under the Progress Notes tab, revealed R78's weight was consistent with the weight documented on 04/04/24 (admission weight). There were no new recommendations. Review of the Weight and Vitals Summary located in the EMR under the Weights and Vitals tab, revealed a weight on 05/01/24 of 165.6 and 05/15/24 of 166.8 which had been struck out by the RD as a disputed value. There were no other documented weights for the month of May 2024. There were no weights documented in the EMR for 05/8/24, 05/24/24, and 05/31/24. The weights documented on 05/1/24 and 05/15/24 were struck out as a disputed value with no re-weigh weight documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR), dated May 2024 and located in the EMR under the Orders tab, revealed weights were taken on 05/01/24, 05/08/24, 05/15/24, 05/24/24, 05/29/24, and 05/31/24, however, there were no weights documented in the EMR for 05/8/24, 05/24/24, and 05/31/24. Review of the MAR, dated June 2024 and located in the EMR under the Orders tab, revealed weights were taken on 06/05/24 and 06/07/24, however there was no weight documented in the EMR. During an interview on 06/12/24 at 11:53 AM, the RD stated that weights were auto populated in the daily nursing assessment from the last documented weight. The RD stated that weights needed to be documented when they were taken, and she was not sure why they were not documented. The RD stated that there were no concerns reported to her about R78's TF or weights. The RD stated she was not notified of any weight changes because the weights had not been entered into the system. The current weight was requested by the surveyor on 06/12/24. A weight of 179.2 lbs. was documented under the Weights and Vitals tab of the EMR, which represented a 4.07% weight loss since the last documented weight on 04/25/24 (48 days). During an interview on 06/13/24 at 9:58 AM, the RD stated she had not been notified of any weight issues with R78 because no weights had been documented. The RD stated that the Unit Manager for the 700 Hall was on leave and had left abruptly leaving work undone which was why there were no current documented weights for R78. During an interview on 06/13/24 at 10:35 AM, Licensed Practical Nurse (LPN) 2, Unit Manager stated she had just been assigned to the 700 Hall in the last two weeks. She stated that weekly weights were taken on Wednesday by the CNA and recorded in the medical record by the Unit Manager. She stated that any weight differences of five lbs. or more should have been reported to the Unit Manager. Review of the undated facility's policy titled, Weight Assessment and Intervention indicated Weights will be recorded in the individual's medical record. NJAC 8:39-27.1

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure that two (2) of two (2) residents (Resident #13 and Resident #40) reviewed for accident hazards were given adequate supervision while transporting hot liquids. This failure caused Resident #13 to have a first degree burn on the pelvic area on 01/05/24 and a first degree burn to the abdomen with second degree burns on the left thigh and penis on 05/10/24. Both burns resulted from Resident #13 heating up coffee in the unit microwave which was located in the unlocked nutritional room on the unit. On 11/01/23, Resident #40 suffered a second degree burn to the right hip from self-transferring coffee from the dining room. On 06/10/24, a Past-Non-Compliance (PNC) Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure residents were safe from accident hazards. The IJ was determined to exist on 05/10/24, when a second-degree burn occurred to Resident #13. The IJ was removed on 05/13/24, when the microwaves were removed from the unit nutritional rooms. The Administrator was informed on 06/10/24 at 10:33 PM, that the PNC Immediate Jeopardy situation existed which also constituted Substandard Quality of Care (SQC) for 42 CFR 483.25-Free of Accident Hazards/Supervision/Devices (F 689). The facility provided an Immediate Jeopardy Removal Plan that was accepted on 06/11/24 at 6:51 PM. The survey team verified the implementation of the Removal Plan through interviews and review of training records on 06/13/24 at 2:15 PM. Based on the facility's implementation of corrective actions, the IJ and SQC were determined to be PNC and the IJ was removed, with substantial compliance achieved on 05/13/24. The deficient practice was determined to be PNC related to the facility identifying the IJ and implementing interventions to prevent reoccurrence of the situation, completed on 05/13/24. The facility's actions included the following: -Resident education and care plans updated as indicated. -On 05/13/24, the interdisciplinary care (IDC) team met to discuss hot beverages policy, microwave use, and reviewed trends surrounding hot beverage spills. -On 05/13/24, microwaves were removed from the common area by Maintenance staff/designee. -On 05/13/24, the resident council president and residents were made aware by unit managers/interdisciplinary team (IDT) that microwaves were removed from common areas by maintenance staff/designee and that requests should be made to staff for reheating of food and beverages. -On 05/13/24, the resident council/food committee was held. Residents were educated on hot beverage safety and the removal of microwaves from common areas. The residents were educated that dietary staff would reheat meals and beverages upon request to minimize the risk of injury and validate appropriate beverage temps before resident consumption and/or transporting of hot beverages. -On 05/13/24, staff education was initiated and remained ongoing. (continued on next page)

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

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-Education on monitoring during meals and during resident transport of hot beverages to assist in minimizing the risk of potential injury and following plan of care. -On 05/13/24, staff were educated to request reheating of meals and beverages from dietary staff. Education to dietary staff regarding reheating food and beverages per policy and facility-initiated process. -On 05/13/24, a review was completed of resident incidents with identified residents reviewed. Care plans were in place, and no further variances were noted. -Kitchen audits related to test trays remain ongoing. Variances addressed as indicated. Findings include: 1. Review of Resident #13's Admission Record, provided by the facility, indicated Resident #13 was readmitted to the facility on [DATE], with diagnoses of diabetes mellitus, chronic pain syndrome, and personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. During an observation and interview on 06/10/24 at 10:20 AM, Resident #13 stated they had a third degree burn to the abdomen, left thigh, and penis. Resident #13 stated that approximately one and half weeks ago during the evening shift around 6:00 PM, they were warming up coffee in the microwave that was located in the nutritional room. Resident #13 stated the hot coffee spilled on them and that they were hollering. Resident #13 stated no staff were around to warm up the coffee and that was the reason Resident #13 warmed it up themselves. Resident #13 stated that he/she warmed up the coffee for two minutes. Resident #13 denied any further incidents. During the interview, Resident #13 was observed to have a healed area to the abdomen. In addition, Resident #13 showed the surveyor their left thigh area, which had a dressing. During another interview on 06/10/24 at 4:28 PM, Resident #13 stated for the 05/10/24 incident, they were heating up coffee in two plastic 16-ounce (oz) cups, which were doubled. Resident #13 stated I was wheeling out of the open door of the nutritional room that had cardboard holding the door open and the cardboard came loose causing the door to bump into my wheelchair. Resident # 13 stated when the door hit my wheelchair; it caused me to spill the coffee. Resident #13 stated the coffee spilled on their left thigh first and then on the abdomen area. Regarding the incident on 01/05/24, Resident #13 stated, I was in the nutritional room, the door was held opened by a piece of cardboard and I got into an altercation with another resident. Resident #13 stated they went into the nutritional room first and was warming up coffee. Resident #13 stated that the other resident pushed him out of the way, while Resident #13 was by the ice machine and attempting to exit the door. Resident #13 stated this was when the coffee spilled on my legs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of "Full Quality Assurance (QA) Report," provided by the facility and dated 01/05/24, revealed " .first degree burn .pelvis area .according to [R #13], tingling sensation on lap (close to groin area), [Resident #13's] skin was normal temperature, normal to touch, no redness, no flaking or scales . preventative/protective skin care, cold compress for five minutes .Conclusion: . [Resident #13] stated the hot coffee fell on me. Upon investigation and interviewing of [Resident #13] and staff [Certified Nursing Assistant (CNA #1)], coffee indeed was noted to spill on [Resident #13's] lap. [CNA #1] was attempting to get fresh ice water for her residents, while [Resident #13] was warming up coffee. [Resident #13] became angry with [CNA #1] for being in the nourishment room at the same time [Resident #13] was in there .In the process of [CNA #1] trying to get past [Resident #13] so the resident would not pour coffee on her, [Resident #13] spilled small amount of coffee on [him/herself] .[Resident #13] was assessed by floor nurse and no changes to skin textures were noted .Nurse Practitioner (NP) notified of first degree burn to groin area; however, no changes were visible at the time and new orders to apply cold compress were initiated . Root Cause: No, [R #13] is self-willed and refuses assistance when offered by staff." Review of the "Occupational Therapy Treatment Encounter Note(s)," provided by the facility and dated 01/12/24, revealed " .During evaluation process patient demonstrated fair safety awareness with use of microwave, associated transfers and management of hot food items. [Resident #13] did endorse having [his/her] own way to do it. Reviewed safety techniques with patient and patient reporting understanding." During another interview on 06/12/24 at 11:00 AM, Resident #13 indicated that the 01/05/24, incident occurred when the Certified Nursing Assistant (CNA #1) came into the nutritional room at the same time Resident #13 was in there. Resident #13 stated I had coffee in my right hand, that I just finished warming up. Resident #13 stated I was getting ready to go out of the nutritional room, when [CNA #1] pushed past me on the right side, causing the hot coffee to spill on me. Resident #13 stated the nurse, [Licensed Practical Nurse (LPN #3)], assessed me and the physician came and saw me. Resident #13 stated that the physician said it was a minor burn. During an interview on 06/12/24 at 11:25 AM, the Director of Rehab (DOR) confirmed that he completed a therapy screen on Resident #13 back in January 2024, that indicated Resident #13 was fairly okay with microwave use. He stated Resident #13 was aware to ask staff for any help. He stated upon Resident #13's hospital return in May 2024, he did not complete a formal evaluation, but did speak with Resident #13. He stated Resident #13 said he/she was not going to drink coffee anymore. Review of the "Full QA Report," provided by the facility and dated 05/10/24, revealed " .burn to mid left abdomen, reddened area initially then started forming blister within half an hour and burn to left thigh, reddened initially then started forming blister in half an hour .cold compressed wrapped in towel .transferred to [name of hospital] .Conclusion: . On 05/10/24 at 5:45 PM, [Resident #13] was utilizing a different cup to warm up their coffee in the microwave, as [Resident #13] removed the cup, [he/she] spilled the hot coffee on themselves. A full nursing assessment was completed by the nurse, and first aid was immediately rendered. [Resident #13] was noted with a reddened area to mid left abdomen and left thigh, cold compress was refused by [Resident #13], and the resident was transferred to the emergency report (ER) .[Resident #13] returned to the facility on [DATE], the resident was informed that the facility policy was changed and that no residents would be allowed to use microwave independently .Root Cause: most likely [Resident #13] has episodes of forgetfulness and refuses to accept care/assistance." (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the undated ''Summary of the Incident,'' provided by the facility and signed by the DON, revealed ''[Resident #13] is a [AGE] year-old .resident that has been residing at [name of facility] since 03/06/23, with medical diagnoses of diabetes, coronary artery disease (CAD), anemia, gastroesophageal reflux disease (GERD), syncope, benign prostatic hyperplasia (BPH). Resident #13's BIMS score was 13 .On 05/10/24 at 5:45 PM, [Resident #13] was utilizing a different cup to warm up the coffee in the microwave, as the resident removed the cup, the hot coffee spilled onto the resident. A full nursing assessment was completed by the nurse, and first aid was immediately rendered. Resident #13 was noted with a reddened area to the mid left abdomen and left thigh, cold compress was refused by [Resident #13], and was transferred to the emergency department (ED) .[Resident #13] was informed that the facility policy was changed and that no residents would be allowed to use microwave independently. The staff will take any item of food or liquids to the kitchen, where the kitchen staff will warm it up. All microwaves have been removed from the units and staff in-serviced on the new policy.'' During an interview on 06/10/24 at 2:13 PM, the Regional Director of Operations stated Resident #13's incident on 05/10/24, was not reported to the state agency (SA). She stated the Ombudsman came out and investigated at which the case was closed. Review of LPN #3's ''Employee's Statement of Incident,'' dated 05/10/24, revealed, ''At around 5:45 PM, while I was feeding a resident. I heard someone screaming in the distance. When I walked out of the room to investigate, I saw [CNA #2] pulling [Resident #13] out of the pantry. [Resident #13] stating that the hot coffee spilled on him/her and the resident was burned. I told [CNA #2] to get ice and called out for [CNA #3] to help. I immediately took [Resident #13] to their room and [CNA #3] followed me there to take Resident #13's clothes and assess. Noted reddened area on left side stomach and left thigh. Non-blanching, sensitive to touch. Ice compression wrapped in towel placed but [Resident #13] cannot tolerate it. Resident #13 then applied petroleum gel cocoa butter to themselves. [Resident #13] requested to be sent to emergency room (ER). Transport unavailable until 11:30 PM. 911 ambulance called instead .Right before 911 ambulance on last check with [Resident #13], skin noted on left thigh forming blisters.'' Review of CNA #2's ''Employee's Statement of Incident,'' dated 05/10/24, revealed ''I was in [room number] .I heard someone yelling .So I went to see who it was and looked in the pantry, it was [Resident #13]. Resident #13 said they had burnt themselves with hot coffee, so I got the nurse.'' Review of CNA #3's undated ''Employee's Statement of Incident,'' revealed ''I was with another resident when I was called by the nurse. The resident [Resident #13] had burned themselves with hot coffee at that time. The nurse and I went in and took care of the resident, and [Resident #13] was sent to the hospital.'' During an interview on 06/10/24 at 12:40 PM, the LPN #1 confirmed Resident #13 had an incident during the evening shift on 05/10/24. She stated Resident #13 warmed up the coffee in the microwave for two to three minutes which was in a plastic cup and caused burns to the Resident #13's left upper thigh, lower abdomen, and groin/penis area. The LPN #1 confirmed that the facility wound physician called the burns third degree. The LPN #1 stated that Monday after the incident, all microwaves were removed from the nutritional units in the facility. The LPN #1 stated if residents needed their food and/or liquids heated up, the staff took them to the dietary department, who re-heated them for the resident. The LPN #1 stated staff and residents were given education, through word of mouth, about these new guidelines. Also, the LPN #1 stated that the incident was reported to the Ombudsman. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation and interview on 06/10/24 at 4:35 PM, LPN #1 stated Resident #13 could transfer themselves into their wheelchair, and that was their mode of transportation. The LPN #1 stated Resident #13 did not walk. LPN #1 confirmed that Resident #13 was independent in their activity of daily living (ADL) and had a history of refusal at times. LPN #1 stated Resident #13 tended to roll themselves backwards in their wheelchair. In addition, during the interview, the nutritional door was observed propped open by a piece of cardboard which was wedged between bottom of door and floor. The LPN #1 stated the nutritional room was usually propped open at the change of shift due to the aides passing ice water. LPN #1 stated that it was made for easy access. LPN #1 could not answer when asked if the door was allowed to be propped open. LPN #1 confirmed the nutritional door was always unlocked. LPN #1 indicated that residents, visitors, and/or staff were allowed to heat up things in the microwave, and staff would always ask residents if they needed any help when staff observed residents using the microwave. When asked if residents had a screen for self-use of the microwave, she stated that after the first incident for Resident #13, he/she was screened by therapy and found safe to use the microwave. She indicated that for the incident on 01/05/24, Resident #13 spilled coffee on themselves during a verbal communication with a staff member. The LPN #1 stated Resident #13 became upset when the staff member came into the nutritional room, and as the resident was backing out, they spilled coffee on themselves. Review of ''Hospital History and Physical,'' provided by the facility and dated 05/11/24, revealed '' .[Resident #13] was having dinner .when he/she spilled coffee to their thigh and penis. [Resident #13] has what appears to be superficial burns on the abdomen with partial thickness burns to his/her thigh and penis. Total body surface area (TBSA) burn: 1% .partial thickness burns .left thigh and penis.'' Review of the ''Quality Assurance Performance Improvement-Action Plan,'' provided by the facility and dated 05/13/24, revealed ''Goal: To ensure resident safety with hot liquids .Resident Communication: Residents have been informed via resident council of the removal of microwave ovens from facility nourishment rooms; to prevent accidentally burns when independently reheating/heating food and hot beverages .target date: 05/31/24. Resident Assessment: Newly admitted /readmitted residents, and those with changes in condition affecting activity of daily living (ADL) functionality/decline will be evaluated by therapy (Occupational Therapy) to determine meal assistance needs .target date: Ongoing. Staff education: Education to facility staff on safety of hot liquids. Reheating of foods by dietary staff; microwave unit removal .target date: 05/18/24. Monitoring: Resident requiring meal assistance including those who receive hot liquids of choice will continue to be monitored by facility staff during dining room, and when eating in rooms to ensure assistance is provided to ensure safety. Residents who request beverages/foods to be re-heated will have this facilitated by facility staff. Dietary staff will continue to monitor food temperatures including hot liquids prior to service to residents. Hot liquids will not be served greater than (>) 180 degrees.'' Review of Resident #13's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/04/23, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact and able to make themselves understood and understood others. 16752 2. Review of the facility's accident/incident log for 2023-2024 and provided by the facility, revealed Resident #40 sustained coffee burns while attempting to transport coffee from the dining room to their room. Resident #40 sustained a second degree burn to the right thigh/hip areas. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility's investigation of the incident, dated 11/01/23, and provided by the facility, revealed Resident #40 had gone to the dining room for coffee. A dietary staff member placed the coffee cup on the dining room table. The report documented the resident deciding to take the coffee to their room. Resident #40 placed the coffee cup inside the right side of their wheelchair next to their right thigh. Review of an undated witness statement provided by the Maintenance Director revealed the employee was coming out of his office when he observed the resident trying get out of the wheelchair after the resident spilled the coffee on themselves. The Maintenance Director assisted the resident to another chair and notified the nurse of the accident. Interventions put in place after included complete pain assessment, frequent skin checks, and treatments as ordered. Educated the resident to ask for assistance for carrying hot items to his/her room, not to attempt wheeling themselves, and trying to carry items at the same time. Staff education to make sure coffee was cooled before offering it to the residents. Review of Resident #40's Nursing notes, dated 11/01/23 at 7:43 PM, located in the resident's EMR under the Progress Notes tab, revealed the nurse was called to resident's room after the resident spilled hot coffee on themselves. The nurse documented the resident was found grimacing in pain. The resident stated that they had placed a cup of hot coffee by their side in the wheelchair as he/she was trying to propel themselves to their room when the coffee spilled and burned them. The physician was notified and ordered Silvadene cream to the burn area every shift. The resident's responsible party was notified. At the time of the incident, the resident was noted to have redness on their right thigh and upper gluteal area. It was determined that this was a first-degree burn. Additional review of Resident #40's nurses notes, dated 11/03/23 at 7:36 PM, it was noted the resident had developed a blister on the right hip area. The MD [Medical Doctor] was notified and ordered the blister to be cleaned and covered with four-by-four dressings. The burn was now classified as a second-degree burn. During an interview on 06/10/24 at 5:15 PM, the Unit Manager, LPN #5 revealed Resident #40 had gone to the dining room and requested a cup of coffee. LPN #5 stated the dietary staff placed the cup on the table and instructed the resident to stay in the dining room with the coffee. LPN #5 stated the resident was a loner and liked to stay in their room. LPN #5 stated the resident decided to take the cup of coffee to their room. She stated the resident placed the cup of coffee in the wheelchair next to their right leg and left the dining room without asking for assistance. LPN #5 stated the Maintenance staff member was passing by and observed the resident had spilled coffee on themselves. She stated the Maintenance staff member notified the nurse and assisted the resident to transfer to another chair. LPN #5 stated the resident was given a complete physical assessment; at that time, and it was noted the resident had redness on the right hip and upper gluteal area. She stated the facility physician was notified, and orders were obtained to apply Silvadene cream to the affected area three times a day. LPN #5 stated on 11/03/23, the resident's burn changed to a second-degree burn. LPN #5 stated both the resident and staff were educated. She stated the resident was educated on asking for help to carry hot items to their room and not attempt wheeling themselves and trying to carry items themselves. She stated staff were educated in making sure that hot tea and coffee were cooled prior to being given to residents upon request. During an observation on 06/12/24 at 5:15 PM, Resident #40 received their dinner tray in their room. The resident was served coffee with a lid covering the cup to prevent spillage. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #40's Admission Record located in the electronic medical records (EMR) under the Profile tab, revealed the resident was initially admitted on [DATE], with diagnoses that included diabetes mellitus type II, depression, acute kidney failure, transient ischemic attacks, and cerebral infarction. Review of Resident #40's five day MDS with an ARD of 07/10/23, located in the resident's EMR under the MDS tab, revealed the resident had a BIMS score 15 out of 15 which indicated the resident had intact cognition. The resident required limited supervision with their activities of daily living (ADLs). Resident #40 utilized a walker and wheelchair for mobility. Review of Resident #40's quarterly MDS with an ARD of 08/28/23, located in the resident's EMR under the MDS tab, revealed the resident had a BIMS score 13 out of 15 which indicated the resident had intact cognition and the resident required supervision with their ADLs. Review of the facility policy titled, "Safe Use of Microwave Ovens," revised 01/08/24, revealed " .Patient Safety: .2. Hot beverages like coffee, tea or hot chocolate should be served with a lid to help prevent spills if needed." Review of facility policy titled, "Safety of Hot Liquids," revised 10/14, revealed " .Appropriate precautions will be implemented to maximize choice of beverages while minimizing the potential for injury." NJAC 8:39-27.1(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observation, interview, and facility policy review, the facility failed to ensure one of seven medication carts was secured and failed to remove expired supplements and blood equipment from one of two medication storage rooms. This failure has the potential to expose residents to hazards of unsecure medications and expired equipment. Findings include: 1. One of three medication carts located at the nurses' station between 800 hall and 700 hall was observed to be unlocked on 06/12/24 at 11:33 AM. Two staff members were in the office at the nurse station with their backs to the window and the unlocked medication was not in their line of sight. Registered Nurse (RN) 4 was engaged in conversation with another staff member. During this time, several staff members passed by the unlocked cart. One Certified Nursing Assistant (CNA) went to the cart for a straw and left. Two unidentified residents were observed walking by the cart. At 11:59 AM, RN4 returned to the unlocked cart. During an interview on 06/12/24 at 11:59 AM RN 4 revealed that she was not aware the cart unlocked. RN4 stated that she never forgot to lock the cart. RN4 immediately reported the incident of the unlocked med cart to Unit Manager Licensed Practical Nurse (LPN) 6. During an interview on 06/12/24 at 12:05 PM Unit Manager, LPN6 revealed the nurses were trained to ensure the medication carts were always secured. LPN6 stated when the nurse was in the office, the medication carts should have been turned towards the office window so that carts were in the nurses' line of sight. 2. Inspection of the medication storage room located between the 700 hall and 800 Halls on 06/12/24 at 3:18 PM revealed the following expired items: -Four of nine BD Instye Auto guard (intravenous catheter), dated as expired on 07/31/22, 11/30/23, 01/31/23 and 12/31/22 -Nine 14 24 gauge by .75-inch intravenous catheters, dated as expired on 01/31/23 and 01/31/24 -Eight-ounce bottle of Jevity 1.2 Cal (therapeutic nutritional supplement), dated as expired February 2024. -Two of two Sampling Collector (instrument used for collecting specimens), dated as expired on 08/19/23 and 11/19/23 -One non-vented viral access spike (used for withdrawing fluids from vials), dated as expired on 03/31/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/12/24 at 3:30 PM with Unit Manager LPN6 revealed after observing the expired items, that she usually checked the medication storage room every Monday and Friday. LPN6 stated that she just checked the medication room yesterday and thought that she had removed all the expired items. LPN6 stated the nurses, and the pharmacy consultant were responsible for checking the medication carts and the medication room for expired drugs. LPN6 also stated she did not realize the blood collection items had expiration dates. Review of the facility's policy titled, Medication Storage and Labeling with a revision date of February 2023, read in part If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items Compartments (including but not limited to, drawers, cabinets, rooms, refrigerator, carts, and boxes) containing medications and biologicals are locked when not in use, and [NAME] or carts used to transport such items are not left unattended if open or otherwise potentially available to others . NJAC 8:39-29.4

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) while providing care for one of five residents (Resident (R) 49) reviewed on Enhanced Barrier Precautions of 29 sample residents. This failure could promote the spread of multi drug resistant organisms throughout the facility. Findings include: Review of R49's Admission Record located in the resident's electronic medical records (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnosis that included aftercare for hip replacement surgery, hemiplegia, hemiparesis affecting the left side, diabetes, mellitus, major depressive disorder, seizures, and cerebral infarct. Review of R49's Weekly Wound Progress Notes, dated 06/06/24 and located in the resident's EMR under the Evaluation tab, documented the resident had an open area on the right buttocks. During an observation on 06/13/24 at 10:45 AM, a sign posted outside R49's room indicated that the resident was on Enhanced Barrier Precautions. The signage directed staff to perform hand hygiene before and after entering the room. Staff were to don (put on) gloves and gowns while providing direct care to the resident. The isolation cart outside the room contained face masks, yellow isolation gowns, and gloves. An unidentified Certified Nursing Assistant (CNA) was observed in the room without a gown giving R49 a bed bath. The CNA asked the nurse to come to the room to give R49 pain medication. Licensed Practical Nurse (LPN) 7 entered the room to administer the resident's pain medication. LPN7 donned gloves to help the CNA complete the resident's bed bath. However, LPN7 did not don a gown as directed on the signage. During an interview on 06/13/24 at 11:00 AM, LPN1 revealed that she observed LPN7 and the CNA not wearing the correct PPE. LPN1 stated R49 was on Enhanced Barrier Precautions due to the open area on his buttocks. During an Interview on 06/13/24 at 1:20 PM, LPN7 stated that he was trying to ensure the resident received his pain medication timely and forgot to don a gown before assisting with resident care. During an interview on 06/13/24 at 6:00 PM, the Infection Preventionist (IP) revealed she was made aware of the incident and conducted a staff in-service on Enhanced Barrier Precautions. NJAC 8:39-19.4