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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness.On 11/20/25 at 9:15 AM, the surveyor in the presence of the Food Service Director (FSD#1) observed the following during the kitchen tour:1. In preparation area #1, the surveyor observed a can opener with a reddish caked-on debris on the handle and can opener blade. Also observed on the spice rack; 16-ounce (oz) garlic powder, 16oz taco seasoning, 16oz poultry seasoning, 16oz old bay seasoning, 16oz plastic bottle with a yellowish oil-like substance, and 26oz container of salt all opened and without a use by or discard labels. Under the preparation table the surveyor observed a 1-gallon container of distilled vinegar opened without a use by or discard label, per Dietary Aide #1 (DA#1) the can opner should be cleaned after each use and everything should be labeled with open/use by dates. 2. In the cooking area, the surveyor observed on the top of the standing dish warmer a dust-like debris, on the top of the standing steamer a dust-like debris, on top of the standing dual stack oven a sticky substance, and on inside of the bottom oven the surveyor observed a blackish burnt on debris. Per the FSD, the cooking equipment was due to be cleaned today following the dinner meal. 3. On the three-spout coffee and hot water dispenser, the surveyor observed on the hot water dispenser spout a whitish colored build up. Per the FSD, the whiteish substance was hard water build up, that would be cleaned immediately.4. Surveyor observed Dietary Aide #2 (DA#2) wearing 4 hooped earrings and hair was not fully restrained under their hairnet. DA#2 stated, my hair should be fully restrained, but I was told if the hooped earrings are dime sized or smaller it is ok, but I will remove them.5. In the 3-door standing freezer, the surveyor observed 3 plastic cups with a frozen liquid and a 20 oz lemonade all not labeled. Per the FSD those frozen items were for personal use of the dietary staff and should not be left in the freezer. 6. In the walk-in refrigerator, the surveyor observed two boxes above the 18 inches from the ceiling, a 2-gallon container of whole milk opened without a opened or use by label. The FSD stated nothing should be stored 18 inches from the ceiling and the milk should be labeled.7. Prior to the lunch meal being served the surveyor observed DA#1 check the temperature of ground chicken without sanitizing the thermometer prior to testing. The FSD pulled the food from the tray line and disposed of it in the garbage. DA#1 stated thermometer should have been sanitized before the food was tested and that the ground chicken had now been contaminated and needed to be disposed of.On 11/20/25 at 12:15 PM, the Regional Food Service Director (RFSD) provide the surveyor with three facility policies. The Receiving policy with a revised date of 2/2023 revealed under the procedures section, 5. All food items will be appropriately labeled and dated through manufacturer packaging or staff notation. The Equipment policy with a revised date of 9/2017 revealed under the procedures section, 1. All equipment will be routinely cleaned and maintained in accordance with manufacturers directions and training materials.3. All food contact equipment will be cleaned and sanitized after every use. The Staff Attire policy with a revised date of 10/2023 revealed under the procedures section, 1. All staff members will have their hair off the shoulders, confined in hair net or cap, and facial hair properly restrained.5. Hand jewelry will be limited to a plain band. Arm jewelry and dangling jewelry is not permitted.On 11/20/25 at 12:30 PM the surveyor met with the FSD and RFSD (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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to review concerns found during kitchen inspection. The FSD stated all concerns with be addressed immediately.On 11/26/2025 at12:45 PM, the surveyor made the Licensed Nursing Home Administrator (LNHA), the Regional Director of Operations (RDO), the Director of Nursing (DON), and the Assistant DON aware of the above mentioned concerns. NJAC 8:39-17.2(g)

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Refer to 756Based on observations, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure that a physician's order for an as needed (PRN) anti-anxiety medication was limited to 14 days for 1 of 6 residents (Resident #89) and b.) follow up on a physicians recommendation for a gradual dose reduction (GDR) of an antipsychotic medication for 1 of 6 residents (Resident #27) reviewed for unnecessary medications.This deficient practice was evidenced by the following:1. On 11/20/2025 at 11:45 AM, the surveyor observed Resident #89 sitting in front of the nurse's station. The surveyor reviewed the electronic medical record (EMR) for Resident #89.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; anxiety disorder, unspecified (a mental health condition that causes excessive and persistent fear or worry that can interfere with daily life) and Alzheimer's Disease, unspecified (a brain disorder that slowly destroys memory and thinking skills). A review of the Minimum Data Set (MDS), an assessment tool dated 9/9/2025 revealed the resident had a Brief Interview for Mental Status (BIMS) of 2 out of 15, indicating the resident was severely cognitively impaired. Further review of the MDS revealed the resident was receiving an antianxiety medication. A review of the individual comprehensive care plan (ICCP) revealed a focus for use of an anti-anxiety medication related to anxiety, date initiated 9/12/2025, with an intervention of consult with physician to consider dosage reduction when clinically appropriate. A review of the Order Summary Report (OSR) revealed a physician's order for ALPRAZolam Oral Tablet (Xanax-an antianxiety medication) 0.25 MG (milligrams) Give 1 tablet orally every 6 hours as needed for anxiety -Start Date 09/16/2025. A review of the September 2025 Medication Administration Record (MAR) revealed the above mentioned medication was administered one time on 9/17/2025 at 1528 (3:28 PM). A review of the October 2025 MAR revealed the above mentioned medication was not administered. A review of the November 2025 MAR revealed the above mentioned medication was not administered. On 11/25/2025 at 1:01 PM, the surveyor interviewed Registered Nurse (RN) #1, who stated she was aware Resident #89 had an active physician's order for Xanax. RN #1 stated the resident hadn't needed the medication. On 11/25/2025 at 1:17 PM, the surveyor interviewed License Practical Nurse/Unit Manger (LPN/UM) #1, who stated a prn antianxiety medication should be ordered for 14 days and then it should be reevaluated. She further stated if a resident was not using a prn medication, it should be discontinued. LPN/UM #1 reviewed the EMR for Resident #89 in the presence of the surveyor and confirmed there was an active physician's order for prn Xanax ordered on 9/16/2025. On 11/25/2025 at 1:36 PM, the surveyor interviewed the Director of Nursing (DON), who stated a prn antianxiety should be ordered for 14 days, then it should be reevaluated and if resident was not using it, it should be discontinued. The DON accessed the EMR in the presence of the surveyor and confirmed there was an active physician's order for prn Xanax ordered on 9/16/2025 for Resident #89. 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. 2. On 11/20/2025 at 11:53 AM, the surveyor observed Resident # 27 in the day room with their head resting on the wall. The resident's eyes were closed. The surveyor reviewed the EMR for Resident #27.A review of the admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; unspecified Dementia, unspecified severity, with other behavior disturbance (a mental disorder that can cause a person to lose the ability to learn, remember, think, solve problems, and make decisions), and major depressive disorder, recurrent, severe psychotic symptoms (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities). A review of the MDS, dated [DATE], revealed the resident had a BIMS of (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	00 out of 15, indicating the resident's cognition was unable to be assessed. Further review revealed the resident was receiving an antipsychotic medication. A review of the ICCP revealed a focus of use of anti-psychotic medication, date initiated 5/13/2024, with an intervention of consult physician to consider dosage reduction when clinically appropriate. A review of the psychiatric progress note for Resident #27 dated 9/16/2025 revealed an assessment/plan:.2. GDR: Discontinue current Seroquel order. Recommend Seroquel (antipsychotic medication) 50 mg PO (by mouth) in the morning, 25 mg PO in the afternoon and 50 mg PO in the evening. B>R (benefits outweigh risk) Please hold this recommendation until [identifier redacted] POA (Power of Attorney) consents. Continue the rest as prescribed, B>R. I attempted to speak with the resident's [identified redacted-resident representative] by phone this afternoon but unfortunately I was unable to reach [identifier redacted] and left a detailed voice message to [identifier redacted] cellphone. A review of the OSR revealed a physician's order for QUEtiapine Fumarate (Seroquel)Tablet 50 MG Give 1 tablet by mouth three times a day (TID) related to MAJOR DEPRESSIVE DISORDER, RECURRENT, SEVERE WITH PSYCHOTIC SYMPTOMS, dated 5/14/2024. A review of the progress notes did not reveal the GDR was addressed.A review of September, October, and November 2025 MARS revealed the above medication was signed daily as given as ordered at 0800 (8:00 AM), 1300 (1:00 PM) and 1700 (5:00 PM). On 11/25/2025 at 1:01 PM, the surveyor interviewed RN #1, who stated if a psychotropic medication was changed, the family would have to consent to it (the medication change) and it (the consent or refusal) would be documented. On 11/25/2025 at 1:17 PM, LPN/UM #1 reviewed the EMR for Resident #89 in the presence of the surveyor and reviewed the psychiatric progress note for Resident #27 dated 9/16/2025. She acknowledged the recommendation to reduce the Seroquel to 50 mg PO in the morning, 25 mg PO in the afternoon and 50 mg PO in the evening. She confirmed that there was an active physician's order for Seroquel 50 mg PO TID dated 10/4/2023. The LPN/UM stated the purpose of a GDR was to get the resident off psychotic medication if it was not necessary, and to decrease side effects, behaviors. She could not speak to why it was not done. On 11/25/2025 at 1:43 PM, the DON accessed Resident's 27's EMR in the presence of the surveyor and reviewed the psychiatric progress note dated 9/16/25 and acknowledged the above mentioned recommendation. She acknowledged the active physician's order for Seroquel 50 mg TID ordered 5/14/25. The DON stated psychiatric GDR recommendations should be done as soon as possible, usually the same day or next day. She added that there should be documentation of the change or the refusal of the change in the EMR. She confirmed that there wasn't any documentation regarding the GDR. 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. A review of the facility's policy Psychotropic Medication Use revision date 2/2025, revealed Policy: Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record.2. Medications in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics. c. Anti-anxiety medications. 3. Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes:.d. determining appropriateness of a gradual dose reduction.PRN medication.3. PRN orders for psychotropic medications are limited to 14 days. a. For psychotropic medications that are NOT antipsychotics: if the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, they will document the rationale for extending the use and include the duration for the PRN order.Gradual Dose Reduction 1. Residents on psychotropic medication receive gradual dose reductions.unless clinically contraindicated, to determine whether the continued use of the medication is benefitting the resident, to find an optimal dose, or in effort to discontinue the medication. N.J.A.C. 8:39-27.1(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, record reviews, interviews and review of pertinent facility documents, it was determined that the facility failed to ensure that blood and urine lab testing ordered by the physician was completed to monitor and potentially identify changes in a resident's health. This deficient practice was identified for one (1) of one (1) resident, Resident #4, reviewed for completion of ordered lab tests. The deficient practice was evidenced by the following: On 11/20/25 at 12:31 PM, during the initial tour, the surveyor observed Resident #4 lying in bed with their eyes closed and a sheet pulled up to their chest. The surveyor reviewed the electronic medical records (EMR) for Resident #4. A review of the admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; muscle wasting and atrophy (the wasting or thinning of muscle mass), adult failure to thrive (a state of progressive decline), moderate protein-calorie malnutrition, and type 2 diabetes mellitus with unspecified complications. A review of the Quarterly Minimum Data Set (MDS), a resident assessment and care screening tool dated 9/20/25, reflected a Brief Interview for Mental Status (BIMS) of 6 out of 15, which indicated the resident had a severe cognitive impairment. A review of the Individual Comprehensive Care Plan (ICCP) reflected a focus area, dated 6/23/25, for a nutritional problem or potential. Interventions included: obtain and monitor lab/diagnostic work as ordered. Report abnormal findings to practitioner. Document findings and interventions. Further review reflected a focus area, dated 9/12/25, for at risk for infection. Interventions included: obtain lab and diagnostics as ordered. Report abnormal findings to practitioner. Document findings and interventions and a focus area, dated 6/20/25, for the resident had impaired skin integrity. Interventions included: obtain lab and diagnostics as ordered. Report abnormal findings to practitioner. Document findings and interventions.A review of the Progress Notes reflected the following:1. A health status note dated 11/10/25 at 12:32 am, indicated the resident's [identifier redacted-representative] was at the bed side, stating the resident looked in pain when urinating. MD made aware. New order for a urinalysis. 2. A Medical Doctor (MD) progress note dated 11/12/25 at 12:11 am, indicated that per nurse, the resident's [identifier redacted-representative] mentioned over the weekend the resident felt pain on urinating. 3. A health status note dated 11/12/25 at 3:15 pm, indicated the resident's [identifier redacted-representative] voiced that the resident reported dysuria, the MD was in to see the resident, no new orders. 4. A MD progress note dated 11/13/25 at 12:24 pm, contained the following: **Dysuria (painful) Check UA (urinalysis)] and Urine C/S (culture and sensitivities to common antibiotics).5. A nursing daily skilled pathway note dated 11/13/25 at 6:38pm, reflected the resident is incontinent of urine, yellow. In addition, the note indicated the resident was experiencing vomiting. Furthermore, the note indicated the doctor was aware of the vomiting. A review of the resident's Order Summary Report included, but was not limited to, the following orders:1. An active order for cbc (a hematology lab panel, complete blood count), and cmp (a chemistry lab panel, comprehensive metabolic panel) weekly on Mondays, with an order date of 8/16/25.2. A completed order for urinalysis with microscopic (examination under a microscope to identify specific cells and elements], one time only for UTI (urinary tract infection) for 1 day, with an order date 11/10/25 and end date 11/11/25.3. A completed order for UA, C&S (urine culture and sensitivities to common antibiotics) one time only for monitoring for 2 days, with an order date 11/12/25 and end date 11/14/25. A review of the Medication Administration Record (MAR) for November 2025 reflected the following:1. An order for cbc, cmp weekly on Mondays, had an X for all dates.2. An order for UA C&S had a checkmark on 11/12/25, with LPN #1's initials, timed 6:14pm.Further review of the MAR did not reflect an order dated 11/10/25 for urinalysis with microscopic. A review of the Lab Results Reports from 8/16/25 up to and including the date of surveyor review on 11/24/25 did not reveal chemistry and hematology lab reports for the following Mondays: 8/25/25, 9/1/25, 9/8/25, 9/15/25, 9/22/25, 9/29/25, 10/6/25, 10/13/25, 10/27/25, 11/3/25, 11/10/25, and 11/17/25. Further review did not reveal urine specimen reports. A review of (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the EMR did not reveal documentation regarding the reason the labs or urine specimens were not obtained. On 11/24/25 at 11:07 AM, the surveyor interviewed the North unit, unit clerk (UC), who stated all labs were done by [laboratory name redacted] and the results would automatically go into the resident's electronic medical records. The UC stated there were no paper copies of lab results maintained on the unit. On 11/25/25 at 12:24 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated she was aware a request was made for a urine specimen for Resident #4 but could not provide additional information. On 11/25/25 at 1:31 PM, the surveyor re-interviewed LPN #1 who stated, the urine culture ordered 11/12/25 was not obtained. LPN #1 stated she recalled Resident #4's representative saying the resident had dysuria. LPN #1 stated Resident #4 had not exhibited any urinary symptoms, and the resident representative had not reported any, since that one time. LPN #1 stated she transcribed the order for the C&S but was not aware of what happened after that. LPN #1 stated the checkmark on the MAR on 11/12/25 indicated the order had been transcribed. When asked by the surveyor how a nurse would determine if a urine specimen was collected or not, LPN #1 stated she would have to get back to the surveyor. On 11/26/25 at 10:59 AM, the surveyor interviewed LPN #2 at the North unit nurses' station. LPN #2 presented the surveyor with a binder. The cover of the binder indicated it was a Daily Lab request log. LPN #2 stated that was where the nurses kept the lab request forms. She stated the lab took the original copy when they came to obtain the specimen, and a copy was left in the binder. In the front inside pocket, the surveyor observed a lab request form for Resident #4. The test requested was a urinalysis with an order date 11/9/25. There was no completion date on the form. The other contents of the binder were tabbed dividers numbered one (1) through 31. LPN #2 stated those tabs were for requests for each day of the month, and more than one month of request forms may be kept in the binder. The surveyor observed behind tab number 10 there was a lab requisition for Resident #4. The test was a urinalysis, with an order date of 11/9/25. The surveyor compared the lab order number of this request form with the request form in the front pocket of the binder, and confirmed they were both copies of the same request. There were no other lab request forms for Resident #4 in the binder. On 11/26/25 at 11:25 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) in the presence of the Director of Nursing (DON). The ADON stated when there was any change in condition of a resident, they notify the MD. The MD may order labs or diagnostic tests. The DON added the MD may also order routine [regularly scheduled] testing depending on the resident. The ADON stated the doctor or nurse would enter orders into the EMR, and added that the nurse would have had to confirm the order if the doctor entered it. That meant the order would not be processed until the nurse reviewed it and marked it as confirmed. The ADON stated there was a tab in the resident's EMR to view all new orders for the day. The nurses should look at that during their shift. The ADON stated that after writing, or confirming, a lab order, the nurse went into the lab portal and put the order in there. Then the nurse printed a request form and put it into the lab book. The laboratory was automatically notified of the order through the portal. The ADON stated the lab sent a technician to obtain specimens on Mondays, Wednesdays, and Fridays every week, or if called for a STAT (Latin abbreviation for immediately) order. The ADON stated the process for collecting specimens was as follows: The lab technician went to the binder and took the request forms for that day and would proceed to obtain the ordered specimens. The lab technician always checked the refrigerator for any urine specimens. The ADON stated the lab results were posted in the resident's EMR under the tab for lab results. There would be a notation from the lab technician if the resident refused, or if the lab technician was unable to draw blood or obtain the specimen for any reason. The ADON stated there was no place in the EMR where the nurse would document a note when labs were ordered or completed. She stated there would be a checkmark on the MAR that meant the order was entered into the lab portal and the request form was printed. The ADON stated the nurses did not document if specimen was or was not obtained. The ADON stated there was no log kept by the facility to track which lab tests were obtained by the lab technician. She stated the results were in the EMR and each nurse looked to see if their resident had (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	labs that day. She added the nurses relayed to the oncoming shift in report, if labs were done and if they were awaiting results. The DON and ADON confirmed that the residents' lab results were no place else except the EMR. The DON stated, if I were the nurse I would follow up on labs if I put the order in, but the nurses should check the results tab in the EMR on their shift. The DON added that the nurse could check the EMR any time during their shift to review results from that day. She added that the review of lab orders should be done by all nurses on any shift, any day, even weekends. The DON stated the unit manager should check to ensure the labs were all completed as ordered. On 11/26/25 at 12:45 PM, during a meeting with the survey team, the DON acknowledged that Resident #4's urine specimen ordered on 11/12/25 was not completed, but that the MD was notified after surveyor inquiry. When asked by the surveyor about the urine specimen ordered on 11/10/25 and the weekly Mondays chemistry and hematology labs, the DON stated there was nothing else available other than what was provided. A review of the facility provided policy titled Lab and Diagnostic Test Results - Clinical Protocol with copyright date 2001 [company name redacted], Incorporated, indicated a subtitle for Assessment and Recognition with the following steps:1. The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs.2. The staff will process test requisitions and arrange for tests. NJAC 8:39-11.2(b)

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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. **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, (continued on next page)

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Avalon Rehabilitation and Healthcare Center	1059 Edinburg Road Hamilton, NJ 08690

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 that all the staff were on the same page.The surveyor inquired about Resident #2's physician notes. In the presence of the surveyor, LPN/UM #1 reviewed the EMR for Resident #2 and confirmed that the attending physician PN were not there from March through November 2025. LPN/UM #1 stated that the resident was hospitalized for six (6) days in June 2025 and 11 days in October 2025 and the expectation from the attending physician was to write H&P note upon re-admission. 4.The surveyor reviewed the closed record/EMR for Resident #125. The surveyor reviewed the Electronic Medical Record (EMR) for Resident #125. A review of the AR revealed the resident was admitted to the facility with diagnoses which included but not limited to: Anxiety disorder and Anemia. A review of the quarterly MDS, dated [DATE], revealed Resident #125 had a BIMS score of 11 out of 15, which indicated the resident had moderately impaired cognition. A review of the EMR revealed an attending physician H&P note dated 4/9/25 and another PN written by the physician dated 4/10/25. Further review of the PN reflected PN from the NP dated 4/10/25, 4/21/25, 7/8/25, 8/11/25.A review of the EMR did not reveal a PN from the attending physician or the NP in May 2025, June 2025, September 2025, October 2025 and November 2025 or that the physician and the NP were consistently alternating monthly visits.On 11/26/25 at 11:56 AM, during an interview with the surveyor, LPN/UM #2 stated the residents on 200 unit were for Short-term and Long-term care. LPN/UM #2 stated the residents should be seen by either their attending physician or the NP within 24-48 hours after admission and then weekly. LPN/UM #2 stated they (physician/NP) should write PN when they made their rounds. The surveyor inquired about Resident #125's attending physician PNs. In the presence of the surveyor, LPN/UM #2 reviewed the EMR for Resident #125 and stated the resident would be seen weekly if they were admitted for skilled nursing. LPN/UM #2 stated Resident #125's attending physician was the facility's Medical Director (MD), who had completed the resident's H&P note dated 4/9/25 and a PN dated 4/10/25. LPN/UM #2 further stated Our Medical Director does not see all our residents. LPN/UM #2 confirmed there were no PN from the attending physician from May through November 2025. On 11/26/25 at 12:45, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant DON, and the Regional Director of Operations (RDO). The surveyor informed them of the above mentioned concerns for Resident #2, #6, #10 and #125. On 12/2/25 at 9:59 AM, the survey team met with the facility administration for responses. The LNHA stated she did not have additional information for the surveyor.On 12/2/25 at 11:35 AM, in the presence of the survey team, the team leader conducted a telephone interview with the MD, who stated residents would be seen two times in subacute units and once a month in LTC units. The MD further stated new admissions would be seen within 48 hours and a PN would be written directly in EMR [Name Redacted].A review of the facility policy Physician Visits revised 4/13 revealed: Policy Statement: The Attending Physician must make visits in accordance with applicable state and federal regulations. Policy Interpretation and Implementation:1.The Attending Physician will visit residents in a timely fashion, consistent with applicable state and federal requirements, and depending on the individual's medical stability, recent and previous medical history, and the presence of medical conditions or problems that cannot be handled readily by phone.2.The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and the at least every sixty (60) days thereafter.4.After the first ninety (90) days, if the attending Physician determines that (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a resident need not be seen by him/her every thirty (30) days, and alternate schedule may be established, but not to exceed every sixty (60) days. A Physician Assistant or Nurse Practitioner may make alternate visits after the initial ninety (90) days following admission, unless restricted law or regulation.5. The attending physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation.NJAC 8:39-23.2 (b)(d)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Refer to F 605Based on observations, interviews, review of the medical record, and review of other facility documentation, it was determined that the facility failed to respond to the monthly Consultant Pharmacist (CP) recommendations. This deficient practice was identified for 2 of 6 residents reviewed for unnecessary medications (Resident #89 and #27).The deficient practice was evidenced by the following: 1. On 11/20/2025 at 11:45 AM, the surveyor observed Resident #89 sitting in front of the nurse's station. The surveyor reviewed the electronic medical record (EMR) for Resident #89.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; anxiety disorder, unspecified, (a mental health condition that causes excessive and persistent fear or worry that can interfere with daily life) and Alzheimer's Disease, unspecified (a brain disorder that slowly destroys memory and thinking skills). A review of the Minimum Data Set (MDS), an assessment tool dated 9/9/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) of 2 out of 15, indicating the resident was severely cognitively impaired. Further review of the MDS revealed the resident was receiving an antianxiety and antidepressant medication. A review of the individual comprehensive care plan (ICCP) revealed a focus of use of an anti-anxiety medication related to anxiety, date initiated 9/12/2025, with an intervention of consult with physician to consider dosage reduction when clinically appropriate. Further review revealed a focus of use anti-depressant medication r/t (related to) depression, dated 9/12/2025. A review of the psychiatric progress note dated 9/16/25 revealed:Psychotropic medications being monitored. Remeron (Mirtazapine) 7.5 mg (milligrams) PO (by mouth) q (every) HS (hour of sleep) Depression. A review of the Order Summary Report (OSR) revealed a physician's order for ALPRAZolam Oral Tablet (Xanax-an antianxiety medication) 0.25 MG Give 1 tablet orally every 6 hours as needed for anxiety -Start Date 09/16/2025 and for Mirtazapine Oral Tablet 7.5 MG (Remeron) Give 1 tablet orally at bedtime for dementia -Start Date 09/12/2025. A review of the September 2025 Medication Administration Record (MAR) revealed the above mentioned Alprazolam was signed as administered one time on 9/17/2025 at 1528 (3:28 PM) and the Mirtazapine was administered daily as ordered at 9:00 PM. A review of the October 2025 and the November 2025 MAR revealed the above mentioned Alprazolam was not administered, and the Mirtazapine was administered daily as ordered at 9:00 PM. A review the progress notes in the EMR from the PC revealed the following notes: -9/13/2025 08:04 Pharmacy Consultant Note Text: ADMIT (admission) MEDS (medications) REVIEWED. MAKE DX (diagnosis) FOR REMERON -10/1/2025 16:33(4:44 PM) Pharmacy Consultant Note Text: psych 9/16-no med changes. Rec(recommend) d/c (discontinue) Xanax if not being used MAKE DX REMERON DEPRESSION no other med issues-11/1/2025 14:37 Pharmacy Consultant Note Text: NO NEW MED ISSUES. PSYCH NOT ADDRESSEDA review of the Certified Pharmacy Consultant recommendations dated 10/1/2025 and 11/1/2025 revealed the same recommendations for both months.7. [name redacted, Resident #89] Make diagnosis Remeron depression per psych consult. Rec d/c PRN Xanax if not being used. 2. On 11/20/2025 at 11:53 AM, the surveyor observed Resident # 27 in the day room with their head resting on the wall. The resident's eyes were closed. The surveyor reviewed the EMR for Resident #27.A review of the admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; unspecified Dementia, unspecified severity, with other behavior disturbance (a mental disorder that can cause a person to lose the ability to learn, remember, think, solve problems, and make decisions), and major depressive disorder, recurrent, severe psychotic symptoms (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities). A review of the MDS, dated [DATE], revealed the resident had a BIMS of 00 out of 15, indicating the resident's cognition was unable to be assessed. Further review revealed (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident was receiving an antipsychotic medication. A review of the ICCP revealed a focus of use of anti-psychotic medication, dated initiated 5/13/2024, with an intervention of consult physician to consider dosage reduction when clinically appropriate. A review of the psychiatric progress note for Resident #27 dated 9/16/2025 revealed an assessment/plan:.2. GDR: Discontinue current Seroquel order. Recommend Seroquel (antipsychotic medication) 50 mg PO (by mouth) in the morning, 25 mg PO in the afternoon and 50 mg PO in the evening. B>R (benefits outweigh the risk). Please hold this recommendation until [identifier redacted] POA (Power of Attorney) consents. Continue the rest as prescribed, B>R. I attempted to speak with the resident's [identified redacted-resident representative] by phone this afternoon but unfortunately I was unable to reach [identifier redacted] and left a detailed voice message to [identifier redacted] cellphone. A review of the OSR revealed a physician's order for QUEtiapine Fumarate (Seroquel)Tablet 50 MG Give 1 tablet by mouth three times a day (TID) related to MAJOR DEPRESSIVE DISORDER, RECURRENT, SEVERE WITH PSYCHOTIC SYMPTOMS, dated 5/14/2024. A review the progress notes in the EMR from the pharmacy PC revealed the following notes: -10/1/2025 16:04 Pharmacy Consultant Note Text: PSYCH 9/16 REC GDR FOR SEROQUEL-PLEASE F/U. NO OTHER MED ISSUES- 11/1/2025 14:27Pharmacy Consultant Note Text: NO NEW MED ISSUES. PSYCH NOT ADDRESSED A review of the Certified Pharmacy Consultant recommendations dated 10/1/2025 and 11/1/2025 revealed the same recommendation for both months.3. [name redacted, Resident #27] Psych 9/16 recommends GDR for Seroquel-please F/U (follow up). On 11/25/2025 at 1:01 PM, the surveyor interviewed Registered Nurse (RN) #1, who stated the PC would call if there were issues with medications and the nurse would then call the doctor to address the concerns. On 11/25/2025 at 1:17 PM, the surveyor interviewed License Practical Nurse/Unit Manger (LPN/UM) #1, who stated the PC recommendations were entered in the EMR, the unit manager should review it and call the physician to make any changes if necessary. She stated the recommendations usually would be addressed immediately. LPN/UM #1 stated the PC also sent a monthly report of any concerns or recommendations and she reviewed it to make sure the recommendations were addressed. LPN/UM #1 reviewed the PC recommendations from 10/1/2025 and 11/1/2025 for Resident # 89 and #27. She could not speak to why the PC's recommendations were not addressed but stated they would be addressed immediately. On 11/25/2025 at 1:36 PM, the surveyor interviewed the Director of Nursing (DON), who stated the PC reviews the charts and then sends an email with his recommendations. She added he also puts a note in the EMR. The DON stated the unit mangers were responsible to follow up on the PC's recommendations and documenting them (the recommendations). The DON reviewed the EMR in the presence of the surveyor for Resident #89 and #27 and acknowledged the PC's recommendations for 10/1/2025 and 11/1/2025, were not addressed. She could not speak to why the PC's recommendations were not addressed. She stated the PC had not come to her about medications not being addressed. On 1/26/2025 at 11:06 AM, the surveyors interviewed the CP via telephone, who stated he reviewed all resident medications monthly. He stated he documented directly in the EMR and he sent his recommendation reports to the Licensed Nursing Home Administrator (LNHA), the DON, the Assistant DON and the unit managers monthly. The CP state the facility had changes in the unit managers so the monthly recommendations had not been addressed. He added, I think they have been addressed now. On 11/26/2025 at12:45 PM, the surveyor made the LNHA, the Regional Director of Operations (RDO), the DON, and the Assistant DON aware of the above mentioned concerns for Resident #89 and #27. A review of the facility's undated policy Medication Regimen Reviews revealed Policy: A licensed pharmacist reviews the medication regimen of each resident at least monthly.2. The purpose of the MMR (medication regimen review) is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. 3. The MRR includes a review of the medical record to prevent, identify, report, and resolve medication related problems, medications errors or other irregularities. NJAC 8:39-29.3(a)(1)

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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. 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 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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) less than 100 or HR (heart rate) less than 60. With a Start Date of 8/13/25. Gabapentin Capsule 300 MG Give 1 tablet by mouth one time a day for neuropathic pain. With a Start Date of 8/13/25. A review of the August 2025 electronic medication administration record (EMAR) revealed for three (3) dialysis days the following dates and times of medications and supplements were not administered: -On 8/14/25 a code number 3 entered for documentation of medication administration at the times of 1400 (2:00 PM) for Hydralazine (a medication used for high blood pressure), 1630 (4:30 PM) for Novolog (insulin) and blood glucose monitoring, and 1700 (5:00 PM) for Prosource (a medical high protein liquid supplement). The corresponding chart codes revealed 3 indicated Absent from facility. -On 8/16/25 a code number 3 was entered for 1700 Coreg, 1630 Novolog, 1700 Prosource and 1630 blood glucose monitoring. In addition, 1400 Hydralazine and Gabapentin had a code number of 22 which corresponded to the chart code of Drug/Treatment not administered.-On 8/30/25 a code number 3 was entered for 1700 Coreg, 1630 Novolog, 1700 Prosource, 1700 Nepro and 1630 blood glucose monitoring. A review of the corresponding EPN for the three (3) dialysis days revealed the following:-on 8/14/25 indicated the above Hydralazine, Novolog, blood glucose monitoring and Prosource were not administered because dialysis. -on 8/16/25 indicated the above Coreg, Novolog, Prosource, blood glucose monitoring, Hydralazine and Gabapentin were not administered because OOF (out of facility) to dialysis. -on 8/30/25 indicated the above Coreg, Nepro, Novolog, Prosource and Blood Glucose monitoring were not administered because OOF for dialysis. A review of the September 2025 EMAR revealed six (6) dialysis days with the following dates and times of medications and supplements were not administered: -On 9/2/25 there was no entry (blank) for documentation of medication administration at the times of 1630 Novolog and blood glucose monitoring and 1700 Coreg, Nepro and Prosource.-On 9/4/25 a code number 5 was entered for 1400 Hydralazine, 1630 Novolog and blood glucose monitoring, 1700 Nepro, Coreg, and Prosource. In addition, a code number of 1 was entered for 1400 Gabapentin. The corresponding code chart indicated 5 was Hold and 1 was Away from facility with meds.-On 9/6/25 a code number 3 was entered for 1630 Novolog and Blood Glucose monitoring, and 1700 Prosource, Nepro and Coreg.-On 9/9/25 a code number 1 was entered for 1630 Novolog and blood glucose monitoring. There was no entry (blank) for 1400 Hydralazine and Gabapentin.-On 9/11/25 there was no entry (blank) for documentation of medication administration at the times of 1400 Hydralazine and Gabapentin. There was a code number 22 entered for 1700 Coreg, Nepro, Prosource and blood glucose monitoring. -On 9/13/25 a code number 3 was entered for 1400 Hydralazine and 1700 Novolog, blood glucose monitoring, Prosource, Nepro and Coreg. A review of the corresponding EPN for the six (6) dialysis days revealed the following:-on 9/2/25 there was no corresponding EPN.-on 9/4/25 indicated the above Coreg and blood glucose monitoring were not administered because at dialysis. And Nepro, Prosource, Hydralazine, Novolog and Gabapentin indicated dialysis.-on 9/6/25 indicated the above Novolog, Prosource and Blood Glucose monitoring were not administered because OOF for dialysis. And Nepro and Coreg indicated OOF.-on 9/9/25 indicated the above Novolog and Blood Glucose monitoring were not administered because at dialysis. There was no corresponding EPN for the blank entries for Hydralazine and Gabapentin.-on 9/11/25 indicated the above Coreg, Nepro, Prosource and Blood Glucose monitoring were not administered because went to dialysis. There was no corresponding EPN for the blank entries for Hydralazine and Gabapentin.-on 9/13/25 indicated the above Hydralazine, Prosource, Nepro and Coreg were not (continued on next page)

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	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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered because OOF. There were no EPN indicating the physician was aware when the resident had not received medications, nourishment supplementation or monitoring as ordered on the above dialysis days. On 11/25/25 at 8:59 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who stated that she administered medications on her unit. LPN #1 stated when residents were scheduled to go to dialysis they should have physician orders that were different on dialysis days if their medications were timed when the resident was out of the facility at dialysis. On 11/25/25 at 9:02 AM, the surveyor interviewed the Unit Manager/LPN (UM/LPN) who stated when residents had to go to dialysis the nurses were required to review medication orders with the physician to change the times of administration if they had to be administered when a resident was out to dialysis. The UM/LPN explained the nurses should not be documenting on the EMAR or EPN that the resident was out to dialysis for a medication administration time. On 11/25/25 at 12:47 PM, the surveyor, with the Director of Nursing (DON) reviewed Resident #166's EMAR documentation. The DON acknowledged Resident #166 went to dialysis Tuesday, Thursday and Saturday and was picked up at 1 PM and there was documentation on the EMAR indicating medications and supplements were not administered because the resident was out of the facility at dialysis. The DON explained that the nurses would be able to administer the 2 PM medications 1 hour before. The DON was unable to speak to whether the physician was aware that medications were being administered before going to dialysis. The DON also stated the nurses should not be documenting that medications were not administered because a resident was out of the facility at dialysis and the physician should have been notified to obtain POs to accommodate scheduled dialysis times. The DON stated that she would have to review the EMAR further and what the nurses had documented in the EPN. On 11/25/25 at 3:09 PM, the surveyor, in the presence of another surveyor, met with the Regional Director of Operations (RDO) who stated that there was a Quality Assurance Performance Improvement (QAPI) in place regarding medications not being administered when a resident was out of the facility for dialysis. The RDO added he would provide the information. On 11/26/25 at 9:05 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and DON. The LNHA stated that the QAPI had to do with documentation of residents missing medications and Had nothing to do with dialysis. The DON acknowledged that the EMAR should not indicate a resident had not received medications because the resident was out of the facility at dialysis since dialysis had scheduled times which the physician should be aware of. On 11/26/25 at 9:10 AM, the surveyor interviewed the LNHA and DON. The DON stated that she had checked with the nurses who had signed as not administering medications to Resident #166 and they thought that they had administered them. The DON acknowledged the documentation contradicted the nurses verbal statements. The DON and LNHA acknowledged if a nurse were unable to administer a medication then an EPN would indicate what had occurred and the physician would be notified for follow up. The DON further stated the times of administration were to be reviewed with the physician to accommodate the scheduled dialysis times. A review of the facility policy End-Stage Renal Disease, Care of a resident with with a revision date as of September 2010 provided by the LNHA revealed Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. In addition, Education and training of staff includes, specifically: . f. timing and administration of medications, particularly those before and after dialysis;. A review of a facility policy Administering Medications with a revision date of April 2019 provided by the LNHA reflected Medications are administered in a safe and timely manner, and as prescribed. In addition, Medications are administered in accordance with prescriber orders, including any required time frame. And Medications administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication;. NJAC: 8:39-11.2(b), 27.1(a), 29.2(a)(d)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to have a process in place to post the daily per shift nurse staffing report. This deficient practice was identified on 11/24/2025. This deficient practice was evidenced by the following: On 11/24/2025 at 8:30 AM, the surveyor observed nurse staffing posted at the front receptionist desk for Friday 11/21/25, day shift. On 11/25/2025 at 9:50 AM, the surveyor interviewed the Staffing/Human Resource (SHR) staff member, who stated she posted the staffing at the desk for day and evening shifts and the night supervisor posted the night shifts. The surveyor asked who posted the staffing on the weekend, the SHR stated I do when I come in on Monday. She added the weekend supervisors do not have access to the reports so she did it on Monday, so it was the real count. On 11/25/2025 at 10:00 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated the nurse staffing was posted at the receptionist desk every day, every shift. She stated on the weekend, the supervisor was supposed to posts it. The surveyor made her aware of the observation on Monday morning of the nurse staffing for day shift 11/21/2025. The LNHA acknowledged the staffing should have been changed. A review of the facility's policy Posting Direct Care Daily Staffing Numbers revised 8/2022 revealed Policy: Our facility will post on a daily basis for each shift nursing data, including number of nursing personnel responsible for providing direct care to residents. 1. Within 2 hours of the beginning of each shift, the number of licensed nurses, and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location and in a clear and readable format. NJAC 8:39-41.2 (a)(b)(c)(d)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, it was determined that the facility failed to ensure a.) insulin pen devices were dated when opened and had expiration dating on the label in two (2) of four (4) medication carts inspected, b.) a medication for inhalation (Budesonide) was labeled when opened and had expiration dating in one (1) of four (4) medication carts inspected, and c.) an insulin pen device was labeled appropriately with a resident's name (Resident #178) in one (1) of four (4) medication carts inspected. The deficient practices were evidenced by the following: On 11/25/25 at 10:32 AM, the surveyor, in the presence of another surveyor, inspected the 200 Hall medication cart in the presence of the Registered Nurse (RN #1). The surveyor observed an insulin pen device for Lispro (a fast-acting insulin) labelled for Resident #179 that had no date when the insulin pen device was removed from the refrigerator. RN #1 stated she was on that cart for the day and had not administered the resident any insulin. RN #1 acknowledged there should be a date when opened and an expiration date on the label. RN #1 removed the undated insulin pen device and stated she would replace it. On 11/25/25 at 10:46 AM, the surveyor, in the presence of another surveyor, inspected the 700 Back Hall medication cart in the presence of the Licensed Practical Nurse (LPN #1). The surveyor observed an Insulin Aspart (a short-acting insulin) pen device labelled for Resident #59 with a date of 10/21 on the baggie and no date when opened or expiration date on the pen device. LPN #1 stated that she was unsure if 10/20 was the date when opened. LPN #1 added that she thought insulin pens expired after approximately a month. The surveyor also observed a Lantus Solos injection (a long-acting insulin) pen device labelled for Resident # 176 with no date when the device was removed from the refrigerator or an expiration date and a Basaglar (a long-acting insulin) 100 units/ml pen labeled for Resident 177 with no date when the device was removed from the refrigerator or an expiration date. In addition, the surveyor observed an Insulin Lispro (a fast-acting insulin) pen device with no date when the device was removed from the refrigerator or an expiration date. LPN #1 stated the date removed from the refrigerator should be on the pen device. Also, there was no resident's name on the Insulin Lispro pen device and there was a first initial and last name on the baggie. LPN #1 was able to identify the Insulin Lispro was for Resident #176 and stated there should be a label from the provider pharmacy with the resident's name. At that time, the surveyor observed a box of Budesonide Inhalation Suspension 0.5 MG/2 ML ampules labelled for Resident #175 with a handwritten written date of 11/1/25 on the box. The surveyor observed inside the box was one opened foil pouch with no date on the pouch when it was opened. LPN#1 could not speak to if the 11/1/25 was the date the pouch was opened and stated the date the pouch was opened should be on the foil pouch. The surveyor, with the LPN #1, reviewed the storage instructions on the box which indicated When an envelope has been opened, the shelf life of the unused ampules is 2 weeks when protected. LPN #1 stated that she would remove the remaining Budesonide Inhalation Suspension ampules. On 11/25/25 at 11:06, the Director of Nursing (DON), joined the surveyors and LPN #1 at the 700 Back Hall medication cart. The DON observed and acknowledged the insulin pen devices had no date when removed from the refrigerator and the Budesonide Inhalation Suspension foil pouch had no date. The DON stated that the nurses should date when the insulin pen devices were removed from the refrigerator and when the Budesonide foil pouch was opened and follow the manufacturer expiration dates. In addition, the DON stated the name of the resident should be on the pen device. The DON instructed LPN #1 to remove and replace the insulin pens that were not dated and the Budesonide Inhalation Suspension ampules. On 11/26/25 at 11:08 AM, the surveyor, in the presence of another surveyor, interviewed the Consultant Pharmacist (CP) via telephone. The CP stated he conducted unit inspections monthly which included checking the medication carts and refrigerators and making sure there were no expired medications. The CP also stated that the insulin pen devices (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had to be dated when removed from the refrigerator because once opened they had a 28-day expiration dating. In addition, the CP stated that he had not done any inservices regarding medication storage but had given handouts for the nurses to use to the DON which identified medications that had to be dated once opened because the expiration dating changed. The CP added that the unit inspections he does were included in his reports. A review of the CP Unit Inspections completed from September 2025 to November 2025 had not identified there was an issue with dating when a pen device was removed from the refrigerator or dating when medications were opened at the time of the inspections. On 11/26/25 at 12:55 PM, the survey team met with the Licensed Nursing Home Administrator, DON and Regional Director of Operations. The DON stated she did not have medication storage handouts from the CP because that was a while ago and was not current. On 12/2/25 at 10:00 AM, the survey team met with the administrative team. The DON stated the nurses were educated on dating when insulin pens were removed from the refrigerator and when medications were opened and following manufacturer expiration dating. A review of the facility policy Medication Labeling and Storage with a revision date of February 2023 provided by the Licensed Nursing Home Administrator reflected Medication label included, at a minimum:.d. expiration date, when applicable; e. resident's name;. In addition, If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items. A review of the manufacturer specifications for Lispro, Insulin Aspart, Basaglar indicated to date when the insulin pen device was removed from refrigeration and the expiration date was 28 days at room temperature once removed. A review of the manufacturer specifications for Budesonide Inhalation Suspension indicated to date when the foil pouch was opened, keep the ampules in the foil pouch and discard after 2 weeks any unused ampules. NJAC 8:39-29.4(g)(h)