STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Rehab and Care Center	2020 Route 23 North Wayne, NJ 07470

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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 - Some	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 facility policy review, the facility failed to date, label, and/or cover food products stored in the kitchen. This failure had the potential to create an environment for food-borne illnesses which could affect 154 of 159 residents who consume food prepared from the facility's kitchen.Findings include:An observation on 06/02/26 from 10:25 AM to 11:15 AM, with the Dietary Manager (DM), revealed the following: The main refrigerator contained 56 carrots in an open plastic bag with no date label.Two halves of lettuce heads in plastic wrap with no date label. An open cardboard box with ten limes with no date label. Two of the limes had visible white spots. Four opened pie shells with no date label. During an interview on 06/02/26 at 11:20 AM, the DM confirmed the above observations and stated that staff should date all refrigerated products once the food items are opened. The DM also stated that there was no schedule for checking all food for date labels or expired food. Review of the facility's policy titled, Pinnacle Dietary Global, which indicated in Section 4. Labeling and Dating: All opened, cut, peeled, or prepared vegetables must be .dated when prepared/opened. Also, in Section 8. Monitoring: The Food Service Director or designee shall . verify date labels. NJAC 8:39-17.2(g)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure one of 42 sampled residents (Resident (R) 2) were treated with dignity and respect in a manner and environment that maintained their quality of life. This failure had the potential to negatively impact the quality of life and self-esteem for the affected residents. Findings include:Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R2 was admitted to the facility on [DATE] with diagnoses of dementia with agitation, left femur fracture, and peripheral vascular disease. Review of R2's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/04/26, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated that R2's cognitive function was moderately impaired. Review of R2's care plan focus initiated on 06/01/26, R2 had a functional ability performance deficit related to activity intolerance, aggressive behavior, confusion, dementia, disease process, impaired balance, limited mobility, limited range of motion, musculoskeletal impairment, and hip pain. In place were the interventions: to provide sponge bath when a full bath or shower cannot be tolerated, and the resident required max assistance by two staff to turn and reposition in bed every two hours and as necessary. During an observation on 06/02/26 at 9:36 AM, R2's door was open and R2 was found in bed undressed from the waist down without a sheet or blanket covering R2, and the privacy curtain was not in use while Certified Nurse Assistant (CNA) 5 was gathering additional supplies from the supplies closet, outside of R2's room, for R2's bed bath in progress. The resident remained exposed while asleep as the brief was opened exposing R2's private area. Social Worker (SW) was called to the room and observed with the surveyor that R2's private area was exposed and the privacy curtain was not pulled to provide privacy for R2. Upon CNA5's return to R2's room, she stated that she covered the resident with a sheet, but the resident took it off. SW reminded CNA5 to make sure to utilize the privacy curtains when providing care to residents. During an interview on 06/02/26 at 12:42 PM, SW stated, .Thank you for bringing that to our attention. We started to provide education on privacy and dignity. During an interview on 06/03/26 at 3:11 PM, CNA5 stated, they were giving R2 a bed bath, and after washing him/her, I put him/her shirt on first. CNA5 saw that she ran out of cream and went out to get the cream. When she came back, she saw the surveyor and the social worker in R2's room. CNA5 continued that she should have brought everything inside the room before starting R2's bath. CNA5 stated that she should have closed the door. CNA5 stated that she covered R2, but he/she took off the blanket. CNA5 stated she should have closed the curtain to protect R2's privacy and cover R2 with a banket. CNA5 stated the curtain doesn't close all the way. An observation on 06/03/26 at 3:18 PM with CNA5 in R2's room revealed that the privacy curtain was loose on the curtain rail, but it was still functioning for it to be pulled all the way around R2's foot of the bed and provide complete privacy. Review of the facility's policy titled, Confidentiality and Personal Privacy dated 10/17, indicated, Our (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility will protect and safeguard resident confidentiality and personal privacy and on Item #2, sub-item d. The facility will strive to protect the resident's privacy regarding his or her personal care. NJAC 8:39-(a)16

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to inform and provide written information for 13 out of 19 residents (Residents (R) 9 R10, R11, R15, R17, R19, R36, R92, R99, R117, R121, R140 and R142 concerning the right to accept or refuse medical or surgical treatment and, at the resident's or family's or legal representative's option, to formulate and advance directive. This failure had the potential to affect the residents' and their legal representatives' right to participate in and be informed of his or her treatment. Findings include:1.Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed Resident (R) 10 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), type II diabetes, and schizoaffective disorder. Review of R10's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/31/21, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated their cognitive function was intact. 2. Review of the admission Record located in the Profile tab of the EMR revealed R17 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy, dementia, and peripheral vascular disease. Review of R17's admission MDS with an ARD of 02/09/25, located in the EMR under the MDS tab, revealed a BIMS score of nine out of 15, which indicated their cognitive function was moderately impaired. 3. Review of the admission Record located in the Profile tab of the EMR revealed R19 was admitted to the facility on [DATE] with diagnoses of cerebral palsy, dementia with behavioral disturbance, and congestive heart failure. Review of R19's admission MDS with an ARD of 10/31/21, located in the EMR under the MDS tab, revealed a BIMS score of zero out of 15, which indicated their cognitive function was severely impaired. 4. Review of the admission Record located in the Profile tab of the EMR revealed R36 was admitted to the facility on [DATE] with diagnoses of hydrocephalus, chronic obstructive pulmonary disease (COPD), and neoplasm of unspecified behavior of brain. Review of R36's admission MDS with an ARD of 01/29/20, located in the EMR under the MDS tab, revealed a BIMS score of 13 out of 15, which indicated their cognitive function was intact. 5. Review of the admission Record located in the Profile tab of the EMR revealed R92 was admitted to the facility on [DATE] with diagnoses of osteomyelitis of the ankle and foot, type II diabetes, and peripheral vascular disease. Review of R92's admission MDS with an ARD of 03/02/20, located in the EMR under the MDS tab, revealed a BIMS score of 14 out of 15, which indicated their cognitive function was intact. 6. Review of the admission Record located in the Profile tab of the EMR revealed Resident (R) 99 was (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted to the facility on [DATE] with diagnoses of COPD, type II diabetes, and pneumonia. Review of R99's admission MDS with an ARD of 08/29/25 located in the EMR under the MDS tab, revealed a BIMS score of five out of 15, which indicated their cognitive function was severely impaired. 7. Review of the admission Record located in the Profile tab of the EMR revealed R117 was admitted to the facility on [DATE] with diagnoses of Parkinson's disease, manic episodes, and heart failure. Review of R117's admission MDS with an ARD of 11/18/19, located in the EMR under the MDS tab, revealed a BIMS score of 15 out of 15, which indicated their cognitive function was intact. 8. Review of the admission Record located in the Profile tab of the EMR revealed R121 was admitted to the facility on [DATE] with diagnoses of paranoid schizophrenia, cerebral infarction, and epilepsy. Review of R117's admission MDS) with an ARD of 04/29/26, located in the EMR under the MDS tab, revealed a BIMS score of 12 out of 15, which indicated their cognitive function was moderately impaired. Review of the EMR for R10, R17, R19, R36, R92, R99, R117, and R121 revealed no evidence of education or discussions in relation to advance directives were provided to the residents or their legal representatives. 9. Review of R140's admission Record, located in the EMR under the Profile tab, revealed R140 was admitted to the facility on [DATE] with diagnoses that included sepsis, unspecified COPD, and methicillin resistant Staphylococcus aureus (MRSA)Review of R140's admission MDS, with an ARD of 04/20/26 and located under the MDS tab of the EMR, revealed R140 had a BIMS score of 15 out of 15, which indicated R140 was cognitively intact. There was no documentation that information, education or offer of assistance to create an advance directive was offered. 10. Review of R142's admission Record, located in the EMR under the Profile tab, revealed R142 was admitted to the facility on [DATE] with diagnoses that included Diverticulitis, peritoneal abscess, and sepsis, Review of R142's admission MDS, with an ARD of 03/23/26 and located under the MDS tab of the EMR, revealed R142 had a BIMS score of 14 out of 15, which indicated R142 was cognitively intact. There was no documentation that information, education or offer of assistance to create an advance directive was offered. 11. Review of R9's admission Record, located in the EMR under the Profile tab, revealed R9 was admitted to the facility on [DATE] with diagnoses that included, unspecified dementia, depression unspecified, and unspecified atrial fibrillation.Review of R9's annual MDS, with an ARD of 03/30/26 and located under the MDS tab of the EMR, revealed R9 had a BIMS score of two out of 15, which indicated R9 was severely cognitively impaired. There was no documentation that information, education or offer of assistance to create an advance directive was offered. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12. Review of R11's admission Record, located in the EMR under the Profile tab, revealed R11 was admitted to the facility on [DATE] with diagnoses that included non-ST elevated myocardial infarction, hypertension, epilepsy unspecified.Review of R11's quarterly MDS, with an ARD of 05/28/26 and located under the MDS tab of the EMR, revealed R11 had a BIMS score of 15 out of 15, which indicated R11 was cognitively intact. There was no documentation that information, education or offer of assistance to create an advance directive was offered. 13. Review of R15's admission Record, located in the EMR under the Profile tab, revealed R15 was admitted to the facility on [DATE] with diagnoses that included pneumonia, sepsis and anxiety disorder.Review of R15's annual MDS, with an ARD of 05/15/26 and located under the MDS tab of the EMR, revealed R15 had a BIMS score of 15 out of 15, which indicated R15 was cognitively intact. There was no documentation that information, education or offer of assistance to create an advance directive was offered. During an interview on 06/03/26 at 3:44 PM, the Social Worker (SW) stated, .There are no advance directives, and they are used for educational purposes only, it's like a legal document that provides wishes, medical care and its normally meshed with a living will, in nursing homes, we only give the education part of the advance directive, the families normally provide it, when we are given POA or living will documentation, if they have it, we only give the education of it all, we don't provide it. If the family doesn't bring it in or doesn't have it, and a lot of times they will just use the POA documentation. During an interview on 06/03/26 at 4:08 PM, the Director of Nursing (DON) stated, .We do a 48–72-hour baseline care plan meeting- we formulate the Portable Medical Orders or Provider Orders for Life-Sustaining Treatment (POLST) and advance care planning. We have the power of attorney or the family in the meeting, and we discuss Advance care planning, meaning, palliative care, chronic disease care, and the goals of care. The advance directives are in the binder. We go by the power of attorney, or the living will if the resident has one. The advanced directives are in the binder. The binder was verified by two surveyors, that the contents of the said binder are the Practitioner Orders for Life-Sustaining Treatment (POLST) and not advance directives. During an interview on 06/03/26 at 4:57 PM, the Assistant Director of Nursing (ADON) stated, .In our initial meeting with the residents or families, we always ask the resident, or family if they have a POLST or advance directive, we do document the POLST but never the advance directive. The POLST is not good enough, the advance directive is the big umbrella. The problem is there is no documentation that we educated the residents on advanced directives. Yes, we read the regulation on advanced directives. Review of the facility's policy titled, Advance Directives dated 12/16, indicated that Advance directives will be respected in accordance with state law and facility policy. Upon admission, the resident will be provided with information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. NJAC 8:39-9.6(e)

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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** Based on record review and interviews the facility failed to ensure Pre-admission Screen and Resident Review (PASARR), an evaluation for serious mental illness and/or intellectual disability, Level I (preliminary assessment) was accurately completed to identify the resident's psychiatric diagnoses for two out of seven residents, (Resident (R) 5 and R19). The failure to accurately complete the assessment created the potential for R5 and R19 not to be assessed to receive specialized services as needed. Findings Include:1. Review of R5's admission Record, found in the electronic medical record (EMR) under the Profile tab, revealed R5 was initially admitted to the facility on [DATE] with diagnoses that included bipolar disorder. Review of R5's annual Minimum Data Set (MDS), located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 03/06/26, revealed R5 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R5 was cognitively intact. The MDS revealed R5 had a diagnosis of bipolar disorder and did not have a Level II PASARR. Review of R5's Care Plan, found under the Care Plan tab in the EMR dated 03/16/22 revealed, .has a behavior problem impulsive behavior r/t [related to] bipolar disorder. Review of R5's PASARR Level I Assessment, provided by the facility and dated 05/12/26 revealed R5 did not have a diagnosis of serious mental illness. 2. Review of R19's admission Record, found in the EMR under the Profile tab, revealed R19 was initially admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, bipolar type. Review of R19's annual MDS, found under the MDS tab of the EMR, with an ARD of 07/05/25, revealed R19 was severely impaired for daily decision making according to a staff assessment for decision making. The MDS revealed R19 had diagnosis of schizophrenia and did not have a Level II PASARR. Review of R19's Care Plan, found under the Care Plan tab in the EMR dated 11/14/22 revealed, .has a mood problem of shouting.Schizophrenia DX [diagnosis]. Review of R19's PASARR Level I Assessment, provided by the facility and dated 04/10/26 revealed R19 did not have a diagnosis of serious mental illness. During an interview on 06/04/26 at 3:03 PM, the Social Worker (SW) stated she had read the instructions wrong when completing the Level I screening assessments for R5 and R19 and confirmed the severe mental illness diagnoses should have been included in the assessment. During an interview on 06/05/26 at 10:37 AM, the Administrator confirmed the Level I screening assessments for R5 and R19 should have included the severe mental illness diagnoses. Review of the facility's policy titled, Behavioral Assessment, Intervention and Monitoring, with a revision date of March 2019, provided by the facility, noted the following:.All residents will receive a Level I PASARR] screen.If level 1 screen indicates that the individual may meet the criteria for a mental disorder, intellectual disability or related condition he or she will be referred to the state (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR representative for the Level II (evaluation and determination) screening process. NJAC 8:39-27.1(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and policy review, the facility failed to provide assistance with activities of daily living (ADLs) for five residents (Resident (R) 6, 16, 9, 140, and R36) reviewed for activities of daily living (ADLs) out of a total sample of 33. This failure increased the potential for residents to have unmet hygiene needs. Findings include:1. Review of R140's admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R140 was admitted to the facility on [DATE] with diagnoses that included sepsis, unspecified chronic obstructive disease (COPD), and methicillin resistant Staphylococcus aureus (MRSA). Review of R140's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/20/26 and located under the MDS tab of the EMR, revealed R140 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R140 was cognitively intact. It was recorded that R140 was dependent on staff for assistance with ADL's and had no documentation of refusing care. Review of R140's Care Plan, located under the Care Plan tab in the EMR, revealed no recorded concerns with rejection of care related to ADLs, including showering, nor that the resident only responded to questions in the negative. Observation on 06/02/26 at 8:21 AM R140 had facial hair approximately 1/2 inches long. Observation on 06/03/26 at 10:00 AM R140 still had facial hair. Observation on 06/04/26 at 10:30 AM R140 still had facial hair. R140 stated they would send his/her son to get razors. 2. Review of R16's admission Record, located in the EMR under the Profile tab, revealed R16 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy, unspecified chronic obstructive disease (COPD), and Type 2 Diabetes. Review of R16's annual MDS, with an ARD of 04/22/26 and located under the MDS tab of the EMR, revealed R16 had a BIMS score of three out of 15, which indicated R16 was severely cognitively impaired. It was recorded that R16 required substantial/maximum assistance for ADLs and had no documentation of refusing care. Review of R16's Care Plan, located under the Care Plan tab in the EMR, revealed no recorded concerns with rejection of care related to ADLs, including showering, nor that the resident only responded to questions in the negative. Observation on 06/03/26 9:03 AM revealed R16 had facial hair greater than 1/2 inch on their chin. Observation on 06/04/26 at 8:30 AM revealed R16 had facial hair greater than 1/2 inch on their chin. 3. Review of R6's admission Record, located in the EMR under the Profile tab, revealed R16 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, hypertension, and Type 2 Diabetes. Review of R6's admission MDS, with an ARD of 04/26/26 and located under the MDS tab of the EMR, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed R6 had a BIMS score of eight out of 15, which indicated R6 was moderately cognitively impaired. It was recorded that R6 was dependent on staff for ADLs with no documentation of refusing care. Review of R6's Care Plan, located under the Care Plan tab in the EMR, revealed no recorded concerns with rejection of care related to ADLs, including showering, nor that the resident only responded to questions in the negative. Observation on 06/02/26 at 3:26 PM revealed R6 needed a shave and R6's fingernails were greater than 1/4 inch over fingertips with brown debris under their nails and around their nail beds. Observation on 06/04/26 at 10:20 AM revealed R6 needed a shave and R6's fingernails were greater than 1/4 inch over fingertips with brown debris under their nails and around their nail beds. Interview on 06/04/26 at 10:20 AM Certified Nurse Aide (CNA)3, while in R6's room, revealed CNA3 was about to change and bathe R6. CNA3 stated R6 fights them, so it takes two staff to do anything. CNA3 said she was afraid to cut R6's nails because she might cut him/her due to him/her fighting. 4. Review of R9's admission Record, located in the EMR under the Profile tab, revealed R9 was admitted to the facility on [DATE] with diagnoses that included, unspecified dementia, depression unspecified, and unspecified atrial fibrillation. Review of R9's annual MDS, with an ARD of 03/30/26 and located under the MDS tab of the EMR, revealed R9 had a BIMS score of two out of 15, which indicated R9 was severely cognitively impaired. It was recorded that R9 required partial/moderate assistance for ADLs and there was no documentation of refusing care. Review of R9's Care Plan, located under the Care Plan tab in the EMR, revealed no recorded concerns with rejection of care related to ADLs, including showering, nor that the resident only responded to questions in the negative. Observation on 06/02/26 at 4:33 PM revealed R9 had facial hair noted greater than 1 inch in length and his/her blouse stained with food. Observation on 06/03/26 at 10:00 AM revealed R9 still had facial hair. Observation on 06/04/26 at 9:15 AM revealed R9 resting in bed. R9 still had facial hair. Interview on 06/04/26 at 10:25 AM with Unit Manager Licensed Practice Nurse (UMLPN)2 revealed the resident's nails should be cleaned and trimmed at each bath or shower and at that time facial hair should be removed if the resident wants. Interview on 06/04/26 at 1:55 PM with CNA4 revealed that I help clean the resident's face and change them; I never shave the resident. Interview on 06/04/26 at 2:05 PM with CNA6 revealed that I washed their (R140 and R9) face, I didn't shave their, I never do that. Interview on 06/04/26 at 2:10 PM with UMLPN1 revealed that our female residents should not have (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facial hair unless they refuse to be shaved, I will get that taken care of. 5. Review of the admission Record located in the Profile tab of the EMR revealed R36 was admitted to the facility on [DATE] with diagnoses of hydrocephalus, osteoarthritis, and chronic obstructive pulmonary disease (COPD). Review of R36's quarterly MDS with an ARD of 05/20/26, located in the EMR under the MDS tab, revealed a BIMS score of 15 out of 15, which indicated that R36's cognitive function was intact. The MDS indicated R36 required partial to moderate assistance for oral care and personal hygiene. Review of R36's Care Plan, focus initiated on 03/24/26 and located under the Care Plan tab of the EMR, revealed that R36 had the potential for functional ability performance deficit related to confusion, dementia, disease process, impaired balance, and limited mobility. Interventions in place indicated that the resident is totally dependent on one staff for personal hygiene and oral care. Review of the document titled, Documentation Survey Report v2 for the months of 05/26 and 06/26, located under the Reports tab of the EMR, revealed that R36 required partial to moderate assistance with oral hygiene and personal hygiene. Observations were conducted on 06/02/26 at 12:49 PM, 06/04/26 at 3:34 PM, and on 06/05/26 at 10:35 AM; R36 was observed with chin hair. During an interview on 06/02/26 at 12:56 PM, R36 stated, I didn't even know that I had this hair on my face. I would like it to be removed. During an interview on 06/05/26 at 10:53 AM, UMLPN2 stated, I do make my rounds on the unit, but the CNAs are the ones responsible for residents' grooming and personal hygiene because it is part of the Activities of Daily Living (ADL) task. The CNAs can find it in the plan of care. Review of the facility's undated policy titled, .Activities of Daily Living (ADL), Supporting, revealed, Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. NJAC 8:39-27.2(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315291	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Rehab and Care Center	2020 Route 23 North Wayne, NJ 07470

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** Based on observations, record review, interviews, and facility policy review, the facility failed to ensure proper personal protective equipment (PPE), was donned (put on) by Licensed Practical Nurse (LPN) 1 prior to entering into one of six sample residents (Resident (R) 92's) room who was under enhanced barrier precaution. This increased the likelihood that infectious organisms could be transmitted from residents to staff, other residents, or the environment.Findings include: Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R92 was admitted to the facility on [DATE] with diagnoses of osteomyelitis on ankle and foot, non-pressure chronic ulcer of left heel and midfoot with unspecified severity, and type II diabetes. Review of R92's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/03/26, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that R92's cognitive function was intact. The MDS indicated R92 required partial to moderate assistance for bed mobility and transfers. Review of R92's Care Plan, found under the Care Plan tab of the EMR, had a focus area of Dialysis, and indicated an intervention dated 04/15/24 of Enhanced Barrier Precautions. Observation conducted on 06/02/26 at 12:35 PM, Licensed Practical Nurse (LPN) 1 was observed entering R92's room with gloves on, a glucometer, a glucometer strip, alcohol wipes, and glucometer lancet (puncture needle). LPN1 was observed at R92's bedside, with gloves on, completed the blood sugar testing with no concern, took off his/her gloves and exited R92's room. During an interview on 06/02/26 at 12:39 PM, LPN 1 stated, .I don't need to put the gown on because I just checked the blood sugar. While reading the enhanced barrier precaution signage posted by R92's room, LPN1 read the signage and stated, .See, I only need to put the personal protective equipment, the gown on when I am providing wound care because R92 has a wound. During an interview on 06/05/26 at 2:26 PM, the Infection Preventionist (IP) stated, .When a resident is on enhanced barrier precautions for a wound and has diabetes, the nurses do not need to wear gowns (PPE) when checking for blood sugar levels. The training that we were given is to only wear the gown when giving high-contact care and checking for blood sugar levels is not high-contact care. Review of the document titled Residents who require Enhanced Barrier Precautions dated 01/06/26, indicated, Enhanced Barrier Precautions (EBP) applies to residents with any of the following (for the duration of their stay, unless condition resolves): item #2. Chronic wounds (for example, pressure ulcers, diabetic ulcers, unhealed surgical wound, venous stasis ulcers). Procedure for EBP: 1. Donning PPE – perform hand hygiene, then don gown and gloves before entering the resident's room or beginning high-contact care. 2. During Care _ Keep gown and gloves on for the entire high-contact activity. 3. Doffing (taking off) PPE – Remove gloves and gown inside the resident's room (or immediately after), perform hand hygiene, and change PPE before caring for the next resident. 4. Face Protection – Use mask + eye protection if splash or spray is anticipated. 5. Shared Equipment – Clean and disinfect after use. Note: EBP does not require resident room restriction or dedicated equipment (unlike full Contact Precautions). NJAC 8:39-19.4(a)