

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 308114	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/02/2025
NAME OF PROVIDER OR SUPPLIER BELLEVILLE SENIOR SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 518 WASHINGTON AVENUE BELLEVILLE, NJ 07109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments Type of Survey: Monitoring / Follow-up Census: AM Session 1- 46 Participants Capacity 110/ per session. On 9/2/2025, the Department of Health conducted a follow-up survey regarding the Office of the Inspector General (OIG) audit that was conducted on 7/24/2024. The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 407	8:43F-6.3(a) General Services The facility shall make reasonable efforts to ensure that all staff providing direct care to participants in the facility are in good health, are concerned for the safety and well-being of participants, and have not been convicted of a crime relating adversely to the person's ability to provide care to participants, except when the applicant or employee with a criminal history has demonstrated his or her rehabilitation, in accordance with the standards set forth at N.J.S.A. 2A:168A-1 et seq., and N.J.A.C. 8:43F-2.1(a)8ii, in order to qualify for employment at the facility.	M 407		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

10/03/25

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M 407	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that all staff had reference and/or criminal background checks upon hire or that the Administrator had a criminal background check upon employment in order to qualify for employment at the facility. Additionally, it was determined that 3 of 4 employees reviewed, Employee #'s 1, 2, 3 and 4, did not have a NJ Exec Order 26.4b1 documented within two weeks of the first day of employment or upon employment. This deficient practice was evidenced by the following: On 7/24/24 the Office of the Inspector General (OIG) conducted an audit at the facility and found that background checks were not completed for Employee #'s 1, 2 and 3. The OIG auditor also found that an Activity Aide (AA) who was employed at the time of the audit, did not have a screening for NJ Ex Order 26.4(b)(1) upon employment. The auditor additionally found that the AA and Employee #'s 2 and 4, did not receive NJ Exec Order 26.4b1 upon employment. On 9/2/25 during the Department of Health's follow up survey, the surveyor interviewed the Administrator who stated that he recently completed background checks on all of the employees, with the exception of Employee #4 who had not worked since NJ Ex Order 26.4(b)(1). The surveyor reviewed the current list of employees provided to the surveyor and observed that the AA included in the OIG's report was not listed. The Administrator confirmed that the AA who was	M 407		

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M 407	Continued From page 2 employed on [REDACTED] NJ Ex Order 26.4(b)(1), was no longer employed at the facility. At 12:30 p.m., the surveyor requested four (4) employee personnel files. Upon review of the employee files, the surveyor observed no documentation to reflect that employee [REDACTED] NJ Ex Order 26.4(b)(1)'s or [REDACTED] NJ Ex Order 26.4(b)(1) screenings were completed upon employment. At 12:45 p.m. the surveyor interviewed the Director of Nursing (DON) who stated that she had the employee [REDACTED] NJ Ex Order 26.4(b)(1) and then provided them to the surveyor for review. The findings were as follows: 1. Employee #1, the Administrator, was employed on [REDACTED] NJ Ex Order 26.4(b)(1). The surveyor observed no documented evidence that a [REDACTED] NJ Ex Order 26.4(b)(1) screening was completed upon employment for the Administrator. The surveyor observed a [REDACTED] NJ Ex Order 26.4(b)(1) dated [REDACTED] NJ Ex Order 26.4(b)(1) but no evidence of an [REDACTED] NJ Ex Order 26.4(b)(1) completed upon the Administrator's employment. Additionally, there was no documented evidence that a criminal background check was completed upon employment until [REDACTED] NJ Ex Order 26.4(b)(1) which was post the OIG audit. 2. Employee #2, the Administrative Assistant, was employed on [REDACTED] NJ Ex Order 26.4(b)(1). The surveyor observed no documented evidence that a [REDACTED] NJ Ex Order 26.4(b)(1) screening was completed upon employment for the employee. Additionally, the surveyor observed that a [REDACTED] NJ Ex Order 26.4(b)(1) was not completed for the employee until [REDACTED] NJ Ex Order 26.4(b)(1). The surveyor observed that references and/or a criminal background check were not completed upon hire until [REDACTED] NJ Ex Order 26.4(b)(1). 3. Employee #3, the Director of Nursing (DON), was employed on [REDACTED] NJ Ex Order 26.4(b)(1). The surveyor	M 407		

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M 407	Continued From page 3 observed no documented evidence that a screening for [REDACTED] was completed upon employment for Employee #3. Additionally, the surveyor observed a [REDACTED] dated [REDACTED] but no evidence of a [REDACTED] completed upon employment for Employee #3 upon employment. The surveyor observed that reference and/or criminal background checks were not completed upon hire until [REDACTED] 4. Employee #4, a Registered Nurse was employed on [REDACTED]. The surveyor observed no documented evidence of a criminal background check, however the surveyor observed that two reference checks were completed. The surveyor additionally observed that there was no documentation of a [REDACTED] completed within the first two weeks of the first day of, or upon employment for Employee #4. At 1:16 p.m., the surveyor interviewed the Administrator regarding [REDACTED] screenings for employees. During the interview, the Administrator stated that he checked with the DON and that he and the DON were unaware of the [REDACTED] screening requirement. The surveyor reviewed an undated facility policy titled, "Infection Control, Sanitation and Housekeeping", which revealed ..."Infection control policies and procedures...(f) Each new employee upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative...the only exceptions...Employee health history and examinations (a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician...within two weeks prior to the first day of employment or upon employment. If the new	M 407		

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M 407	Continued From page 4 employee receives a nursing assessment upon employment, the physician, advanced practice nurse or physician's assistant examination may be deferred for up to 30 days from the first day of employment..." Additionally, the surveyor reviewed a facility policy titled, "General Services...General Staffing Requirements", dated 11/15/15, which revealed, ..."(a) The facility shall make reasonable efforts to ensure that all staff providing direct care to participants in the facility ... have not been convicted of a crime relating adversely to the person's ability to provide care to participants...1. In adult day health services facilities, "reasonable efforts" shall include, but not be limited to...reference checks, and/or criminal background checks...i. Administrators and owners of adult day health services facilities shall have clearance from the Criminal Background Investigation in accordance with N.J.A.C. 8:43-2.1 (a) 9..."	M 407			
M 421	- 8:43F-6.3(e)(1)(i) General Services (e) The facility shall develop and implement a staff orientation plan and a staff training and education plan, including plans for each service and designation of person(s) responsible for	M 421			

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M 421	Continued From page 5 ongoing training. 1. All staff shall receive orientation at the time of employment and ongoing in-service training regarding, at a minimum, emergency plans and procedures, the infection prevention and control services, participant rights, and elder abuse. i. The facility shall document ongoing in-service training of all staff. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that all employees received ongoing annual in-services which included emergency plan and procedures, infection prevention and control, participant rights and elder abuse. This deficient practice was evidenced by the following: On 7/24/24 the Office of the Inspector General (OIG) conducted an audit and found that the facility failed to ensure that drills of emergency plans were conducted at least four (4) times a year, to include at least one drill for emergencies due to a fire. The OIG further determined that three (3) employees, Employee #'s 5, 6 and 7, did not participate in emergency drills in 2023 or 2024.	M 421			

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M 421	Continued From page 6 1. On 9/2/25, the surveyor reviewed Employee #4's personnel file which revealed that the employee was a Registered Nurse and was employed on [REDACTED] NJ Ex Order 26.4(b)(1). Review of the employee's personnel file revealed a document titled, "New Employee Basic Orientation", dated [REDACTED] NJ Ex Order 26.4(b)(1) which included the topics, Infection Control/ Hand washing techniques, Blood borne pathogens/TB facts, Member's rights, Elder abuse and Fire Safety/Emergency Procedures." However, there was no documentation of ongoing annual in-services for the employee. During interview with the Administrator, he stated that Employee #4 only [REDACTED] NJ Ex Order 26.4(b)(1) and that the last time she worked at the facility was in [REDACTED] NJ Ex Order 26.4(b)(1), so therefore had not attended the in-services. The surveyor interviewed the Administrator regarding the emergency and fire drills and the Administrator stated that the facility conducted fire and emergency drills and provided the surveyor documentation of the drills and in-service lists. 2. The surveyor observed that Employee #5, a Certified Medication Aide, was employed on [REDACTED] NJ Ex Order 26.4(b)(1). The surveyor reviewed the in-service lists which revealed that Employee #5 attended the Emergency Procedure in-service on [REDACTED] NJ Ex Order 26.4(b)(1) and [REDACTED] NJ Ex Order 26.4(b)(1). However, there was no further documentation of in-services until [REDACTED] NJ Ex Order 26.4(b)(1) post OIG visit on [REDACTED] NJ Ex Order 26.4(b)(1). 3. The surveyor observed that Employee #6 who no longer worked at the facility was employed on [REDACTED] NJ Ex Order 26.4(b)(1). The surveyor reviewed the in-service lists which revealed that Employee #6 attended	M 421		

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M 421	Continued From page 7 the Emergency Procedures in-service dated [REDACTED] , post OIG visit on [REDACTED] . 4. The surveyor observed that Employee #7, a Driver was employed on [REDACTED] . The surveyor reviewed the in-service lists which revealed that Employee #7 attended the Emergency Procedures in-service on [REDACTED] . The surveyor observed no other documentation to reflect that Employee #7 attended any other drills. The surveyor reviewed a facility policy titled, ... Policy and Procedures ... "Subject: Staff Development and In-Service Concerns: dated 6/26/23, which revealed the following: "Policy: General Orientation: The Administrator shall be responsible for providing each employee at the Center with an Orientation Program at the time of his/her entry on duty...Failure to attend two (2) assigned orientation sessions will result in suspension until such time as the employee complies with this requirement. All employees, including re-hires who have 30 days or more of a gap in service, are required to attend a General Orientation ..." The surveyor reviewed an additional undated policy titled, " Emergency Services and Procedures " , which revealed, ... " Staff orientation: The administrator organizes fire emergency orientation sessions for all staff upon hire _and annually...New staff and volunteers receive special orientations when staring their assignments. In addition to the internally organized training sessions, the fire department may be asked to provide additional orientation and training periodically ...The administrator organizes simulated drills on fire, medical emergency, disaster and equipment power failure	M 421		

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M 421	Continued From page 8 on each shift at least four times a year. A record is maintained of each such drill..."	M 421			
M 701	8:43F-15.3(a)(1) Medical Records (a) The participant's complete medical record shall include, but not be limited to, the following: 1. Participant identification data, including name, date of admission, address, date of birth, race, religion (optional), sex, referral source, payment plan, marital status, and the name, address, and telephone number of the person(s) to be notified in an emergency, and travel directions to the participant's home. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that the facility failed to ensure that a Participant's emergency contact phone number was included in the participant's medical record for 1 of 3 residents reviewed, Participant #3. This deficient practice was evidenced by the following: On 7/24/24 the Office of the Inspector General (OIG) conducted an audit at the facility and found that an emergency contact for Participant #3 was missing. The OIG additionally found that a plan of care was not completed within thirty (30) days of admission for another participant, Participant #4.	M 701			

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M 701	Continued From page 9 1. On 9/2/25 at 11:40 a.m., during interview with the Administrator, the surveyor inquired about Participant #4 included in the OIG's audit. The Administrator stated that Participant #4 no longer attended the program. The surveyor reviewed a sample of three (3) participant medical records, Participant #'s, 1, 2 and 3 and observed that all 3 MR had interdisciplinary plans of care that were developed on admission. 2. At 12:00 p.m., the surveyor reviewed Participant #3' MR, which revealed an enrollment date of NJ Ex Order 26.4(b)(1) and diagnoses of NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The MR face sheet revealed an emergency contact name, however there was no phone number observed for Participant #3's emergency contact. During interview with the Administrator, he acknowledged that Participant #3's Emergency contact phone number should have been included on the face sheet.	M 701		
M 813	8:43F-16.7(a)(1-23) Infection Control, Santation, Housekeeping (a) The following housekeeping, sanitation, and safety conditions shall be met: 1. The facility and its contents shall be free of dirt, debris, and insect and rodent harborages; 2. Nonskid wax shall be used on all waxed floors;	M 813		

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M 813	Continued From page 10 3. All rooms shall be ventilated to help prevent condensation, mold growth, and noxious odors; 4. All participant areas shall be free of noxious odors; 5. Throw rugs or scatter rugs shall not be used in the facility; 6. All furnishings shall be clean and in good repair, and mechanical equipment shall be in working order. Equipment shall be kept covered to protect from contamination and accessible for cleaning and inspection. Broken or worn items shall be repaired, replaced, or removed promptly; 7. All equipment shall have unobstructed space provided for operation; 8. All equipment and materials necessary for cleaning, disinfecting, and sterilizing shall be provided; 9. Thermometers which are accurate to within three degrees Fahrenheit shall be maintained in refrigerators, freezers, and storerooms used for perishable and other items subject to deterioration; 10. Pesticides shall be applied in accordance with N.J.A.C. 7:30; 11. Articles in storage shall be elevated from the floor and away from walls; 12. All poisonous and toxic materials shall be	M 813		

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M 813	Continued From page 11 identified, labeled, and stored in a locked cabinet or room that is used for no other purpose; 13. Combustible materials shall not be stored in heater rooms or within 18 feet of any heater located in an open basement; 14. Paints, varnishes, lacquers, thinners, and all other flammable materials shall be stored in closed metal cabinets or containers; 15. Unobstructed aisles shall be provided in storage areas; 16. A program shall be maintained to keep rodents, flies, roaches, and other vermin out of the facility; 17. Toilet tissue, soap dispenser, paper towels or air dryers, and waste receptacles shall be provided in each bathroom at all times; 18. All solid or liquid waste that is not regulated medical waste, garbage, and trash shall be collected, stored, and disposed of in accordance with the rules of the New Jersey Department of Environmental Protection and the New Jersey Department of Health and Senior Services. Solid waste shall be stored in insect-proof, rodent-proof, and fire-proof, non-absorbent, watertight containers with tight-fitting covers and collected from storage areas regularly, so as to prevent nuisances such as odors. Procedures and schedules shall be established and implemented for the cleaning	M 813		

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M 813	Continued From page 12 of storage areas and containers for solid or liquid waste, garbage, and trash, in accordance with N.J.A.C. 8:24; 19. Garbage compactors shall be located on an impervious pad that is graded to a drain. The drain shall be unobstructed and connected to the sanitary sewage disposal system; 20. Plastic bags shall be used for solid waste removal. Bags shall be of sufficient strength to safely contain waste from point of origin to point of disposal and shall be effectively closed prior to disposal; 21. Draperies, upholstery, and other fabrics or decorations shall be fire-resistant and flameproof; 22. Wastebaskets and ashtrays shall be made of noncombustible materials; 23. Latex foam pillows shall be prohibited. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to	M 813			

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M 813	Continued From page 13 ensure a sanitary and safe environment for the participants; and, failed to ensure that all poisonous and toxic materials were stored in a locked cabinet or room that was used for no other purpose. This deficient practice was evidenced by the following: On 7/24/25, the Office of Inspector General (OIG) conducted an audit at the facility and found several concerns related to health and safety including, toxic materials that were left in multiple unlocked areas and unsecured items that posed an additional safety hazard to the participants. On 9/2/25 the surveyor conducted a follow up survey. The surveyor observed that the picture frame observed by the OIG had been removed and was no longer hanging off the wall. The surveyor also observed that the auditor additionally observed that there were large folded tables unsecured and leaning against the wall in the Quite room, which posed a safety hazard. During the survey on 9/2/25, the surveyor observed that the tables had been removed. On 9/2/25 at 9:50 a.m., the surveyor toured the facility with the Administrator. The surveyor observed a room which the Administrator identified as the employee lounge, which included a bathroom. There was also a closet labeled "Janitorial" within the employee lounge which was locked. 1. In the presence of the Administrator, the surveyor observed that there was a plastic bottle on top of the toilet tank lid in the bathroom, which contained a yellow liquid. The bottle had a label on the back which contained instructions and the cautionary warning, "Keep out of reach of children"; however, there was no label observed on the front of the bottle which identified what the	M 813			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 308114	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/02/2025
NAME OF PROVIDER OR SUPPLIER BELLEVILLE SENIOR SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 518 WASHINGTON AVENUE BELLEVILLE, NJ 07109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 813	Continued From page 14 product was. The surveyor also observed that in the main area of the employee lounge, there was a wooden cabinet located near the floor, to the far right side which contained chemicals that included: 1. "NJ Ex Order 26.4(b)(1)" with the cautionary warning, "Keep out of reach of children" 2. "NJ Ex Ord Boric Acid Roach Killer," with the cautionary warning, "Keep out of reach of children" 3. A large refill container of hand sanitizer labeled 70% ethanol 4. A container of "NJ Ex Ord" cleaner 5. A container of wall finishing. The surveyor observed that the cabinet which contained the chemicals did not properly close all the way or have a lock in place. The surveyor additionally observed that although the employee bathroom had a lock on the door, there was no lock on the entrance door to the employee lounge and therefore accessible to the Participants. 2. At 10:01 a.m., during the tour, the surveyor observed a room which the Administrator identified as the beauty salon. The beauty salon was located next to the large main activity/ dining room which was occupied by multiple participants who were engaging in activities. The surveyor observed a basket on a shelf near the floor which contained two bottles of "NJ Ex Order 26.4" cleaner with bleach. The surveyor additionally observed cabinets on the wall which contained two bottles of pure acetone and seven bottles of various hair product aerosols. The surveyor interviewed the Hair dresser, who was in the beauty parlor, and she stated that	M 813		

New Jersey Department of Health

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NAME OF PROVIDER OR SUPPLIER BELLEVILLE SENIOR SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 518 WASHINGTON AVENUE BELLEVILLE, NJ 07109		
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M 813	Continued From page 15 there was a lock on the right cabinet where the products were observed but stated that the lock was broken. The surveyor observed that there was also a lock on the left side of the cabinet, however the Hair dresser stated that she did not have the key. During continued surveyor interview, the surveyor inquired about the key to the salon entrance door, and she stated that she did not have a key to the door. The surveyor interviewed the Administrator and inquired about whose responsibility it was to lock the beauty salon. The Administrator stated that either the housekeeper or maintenance unlocked the beauty parlor door in the morning and then locked the door in the evening. 3. At 10:05 a.m. the surveyor observed a room identified by the Administrator as the nursing office, which also contained a bathroom. The Administrator explained that the bathroom was utilized by the nursing staff but also utilized by participants who required assistance. The surveyor observed a 64-ounce container of bleach on top of the garbage can in the nursing office bathroom, three folded wheelchairs and two walkers against the wall to the right of the nursing office bathroom sink. During interview with the Administrator regarding above concerns, he stated that the walkers and wheelchairs were kept in the nursing office bathroom so that they could be readily available to the nursing staff in an emergency. 4. At 11:05 a.m., the surveyor went back to re-inspect the Janitor closet located in the employee lounge and observed the door to the Janitorial closet was unlocked. The surveyor observed the following within with Janitorial	M 813		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 308114	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/02/2025
NAME OF PROVIDER OR SUPPLIER BELLEVILLE SENIOR SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 518 WASHINGTON AVENUE BELLEVILLE, NJ 07109		
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M 813	Continued From page 16 closet: a. 6 bottles of bleach disinfectant with the cautionary warning, "Keep out of reach of children." b. 1 169 fluid ounce bottle of [REDACTED] Multi-purpose cleaner with the cautionary warning, "Keep out of reach of children." c. 2 boxes of [REDACTED] Indoor Fogger". d. 1 large bottle of [REDACTED], a floor sealer/ finish. The surveyor further observed that there was a broken ceiling panel to the right side of the ceiling in the Janitorial closet which exposed a pipe and a sprinkler head. The surveyor interviewed the Administrator regarding the Janitorial closet that was unlocked and he stated that the Janitorial closet was always kept locked and that maintenance was restocking items. 5. The surveyor toured a room identified by the Administrator as the "Quiet Room," and observed the following: A gray chair that had a gray padded material with multiple large, dark, irregular shaped stains covering the seat of the chair. The surveyor also observed a gray recliner chair that had a black cloth covering, which contained multiple white, dried, crust like stains to one of the chair arms. Additionally, the surveyor observed a double door in the Quiet room with broken lock and behind the door, there was a ladder leaning against the wall, boxes and storage items. During surveyor interview with the Administrator, he explained that the back area of the Quiet room	M 813		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 308114	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/02/2025
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M 813	Continued From page 17 was utilized as a "staging closet" where activities were set up and stored. During the Office of Inspector General (OIG) visit on 7/24/24, the auditor observed a large picture frame that was hanging partially off of the wall in the employee lounge. On 9/2/25, the surveyor observed that the picture frame observed by the auditor had been removed and was no longer hanging off of the wall. On 7/24/24 the auditor also observed that there were large folded tables unsecured and leaning against the wall in the Quite room, which posed a safety hazard. During the survey on 9/2/25, the surveyor observed that the tables had been removed. 6. Additionally on 7/24/24, the auditor observed that there were multiple fire extinguishers that were not inspected annually, and the last inspection date observed by the auditor was December of 2022. On 9/2/25 at 9:55 a.m., while on tour of the facility with the Administrator, the surveyor observed three fire extinguishers that had inspection tags which revealed that they were inspected in August of 2025. The Administrator additionally provided the surveyor with a document titled, "Inspection Certificate" from the local township Fire Department, which indicated, "This certifies that the referenced property has been inspected pursuant to the Uniform Fire Safety Act and satisfies minimum requirements of the New Jersey Uniform Fire Code". The surveyor observed that the document contained the following dates of inspection with signatures: 12/2/19, 9/27/21, 9/27/22, 9/19/23, 7/23/24 and 8/12/25.	M 813			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 308114	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/02/2025
NAME OF PROVIDER OR SUPPLIER BELLEVILLE SENIOR SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 518 WASHINGTON AVENUE BELLEVILLE, NJ 07109		
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M 813	Continued From page 18 At 2:16 p.m., during interview with the Administrator the surveyor inquired about the fire extinguisher inspections. The Administrator acknowledged that the year before the auditor's came, there was a lapse in the fire extinguisher inspection, because the company who conducted the inspections "got bought out and merged" and there was a different person responsible for the scheduling.	M 813			

POC received 10/15/25
Accepted 10/16/25



REVISED PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 308114

NAME OF PROVIDER: BELLEVILLE SENIOR SERVICES

DATE OF SURVEY: 09/02/2025

Tag M407 8:43F-6.3(a) General Services

- **How the corrective action will be accomplished for those residents found to have been affected:**
 - The Administrator (Employee #1), Administrative Assistant (Employee #2), and Director of Nursing (Employee #3) will undergo a ^{NJ Ex Ord} screening as required.
 - In July 2025, criminal background checks were performed on all current employees with background checks older than ^{NJ Ex Order 26.4(b)(1)} including Employees #1, #2, and #3. Employee ^{NJ Ex Order} that were outdated will be updated.
- **How the facility will identify other residents having the potential to be affected:**
 - All participants have the potential to be affected by this practice.
- **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
 - The Administrator, Medical Director, and Director of Nursing, in consultation with our Records Review Consultant, developed a new policy and procedure, "TB Screening and Testing," on September 8, 2025. This policy was updated to explicitly include the regulatory timeframe requiring new employees to have a history and physical (H&P) examination within two weeks prior to the first day of employment or upon employment.
 - The Administrator will develop a comprehensive Human Resources (HR) On-Boarding Checklist. This checklist will include mandatory items such as



Application, HR Packet, Photo ID, Social Security Card, Physical/H&P, TB Screening, and Criminal Background Check, and must be signed by both the Administrator and the new hire's department head.

- **How the facility will monitor its corrective actions:**
 - All employee TB screenings and updated H&Ps will be completed by October 31, 2025. The HR On-Boarding Checklist will be implemented by October 31, 2025, and will be used for all new hires on an ongoing basis to ensure compliance.

Tag M421 8:43F-6.3(e)(1)(i) General Services

- **How the corrective action will be accomplished for those residents found to have been affected:**
 - Employee #5 and Employee #7 will receive the annual and emergency in-service training to update their status.
 - Employee #7 will participate in the next scheduled emergency drill to ensure full compliance and familiarity with procedures.
 - Employee #4, who works on **NJ Ex Order 26.4(b)(1)** and has not worked since **NJ Ex Order 26** will be required to complete all outstanding annual and emergency in-service training prior to being scheduled for their next shift.
- **How the facility will identify other residents having the potential to be affected:**
 - All participants have the potential to be affected by this practice.
- **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
 - Beginning in October 2025, mandatory in-services will be offered on multiple days and times each month to increase availability and ensure all staff can attend.



- To ensure full attendance, an active employee list will be printed and checked against the in-service sign-in sheet by the Administrator and an administrative assistant. Any employee who misses the scheduled sessions will be required to complete the training before their next shift.
 - **How the facility will monitor its corrective actions:**
 - This new in-service scheduling and verification process will begin with the October 2025 in-service and be completed by October 31, 2025, and will be an ongoing practice.
-

Tag M701 8:43F-15.3(a)(1) Medical Records

- **How the corrective action will be accomplished for those residents found to have been affected:**
 - The Director of Social Services will make a renewed effort to contact the emergency contact for Participant #3 to obtain and document a valid phone number.
- **How the facility will identify other residents having the potential to be affected:**
 - All participants have the potential to be affected by this practice.
- **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
 - The Director of Nursing (DON) and Director of Social Services will review all participant records for completeness.
 - To address participants with no emergency contact, the following procedure will be implemented: If a participant has no emergency contact, they will be consulted to determine if they are their own responsible party (RP). If so, this will be clearly documented on the face sheet. If the participant is not their own RP



and an emergency contact refuses to provide information, this refusal and all efforts made to obtain the information will be documented on the face sheet.

- **How the facility will monitor its corrective actions:**
 - The full chart review will be completed by October 31, 2025. On an ongoing basis, the Assistant Administrator will review all new participant charts seven (7) days after admission to flag and correct any missing information.

Tag M813 8:43F-16.7(a)(1-23) Infection Control, Sanitation, Housekeeping

- **How the corrective action will be accomplished for those residents found to have been affected:**
 - All specific environmental hazards identified in the survey have been corrected as follows:
 - **Employee Lounge/Bathroom:** The unlabeled plastic bottle was removed on September 3, 2025. The wooden cabinet has been repaired, and a lock has been installed by October 5, 2025. All chemicals (including bedbug spray and roach killer) were secured and locked in a cabinet on September 3, 2025. A new vanity has been installed in the bathroom with a lock.
 - **Beauty Salon:** A new enclosed cabinet has been purchased and locks installed. Locks on existing cabinets have been repaired, and all chemicals (cleaner, acetone, aerosols) are now secured. All chemicals were removed and secured on September 3, 2025.
 - **Nursing Office:** The 64-ounce container of bleach has been moved to a locked janitorial closet on September 3, 2025. The folded wheelchairs and walkers have been relocated to an appropriate storage area on September 3, 2025.



- **Janitorial Closet:** The closet door is now kept locked at all times. The broken ceiling panel has been repaired will be repaired by October 31, 2025.
- **Quiet Room:** The stained chairs have been scheduled for a deep cleaning, and any chair that cannot be cleaned will be replaced. The broken lock on the double door will be repaired to secure the back storage area by October 31, 2025.
- **How the facility will identify other residents having the potential to be affected:**
 - All participants have the potential to be affected by this practice.
- **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
 - All cabinets containing poisonous or toxic materials throughout the facility will be repaired and have locks installed.
 - The entire staff, including the cleaning and maintenance crew, will be in-serviced on "Housekeeping, Hazardous Material, and Fall Hazards" with an emphasis on ensuring all chemicals are secured in locked cabinets when not in use.
 - All upholstered furniture will be put on a monthly schedule for deep cleaning.
- **How the facility will monitor its corrective actions:**
 - The Administrator will develop and implement a "Physical Plant Audit Tool". This tool will be used to conduct weekly audits for three months to specifically monitor that hazardous materials are locked, fall hazards are removed, and furniture is in good repair. After the initial three-month period, these audits will be conducted monthly on an ongoing basis. This process will be completed by October 31, 2025, and will be ongoing.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 308114	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 10/16/2025
NAME OF FACILITY BELLEVILLE SENIOR SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 518 WASHINGTON AVENUE BELLEVILLE, NJ 07109	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix M0407	Correction	ID Prefix M0421	Correction	ID Prefix M0701	Correction
Reg. # 8:43F-6.3(a)	Completed	Reg. # 8:43F-6.3(e)(1)(i)	Completed	Reg. # 8:43F-15.3(a)(1)	Completed
LSC	10/31/2025	LSC	10/31/2025	LSC	10/31/2025
ID Prefix M0813	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:43F-16.7(a)(1-23)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/31/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR		DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/2/2025		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			