PRINTED: 11/08/2024 FORM APPROVED OMB NO. 0938-0391

AND BLAN OF CORRECTION INDENTIFICATION NUMBER:		` ′		DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315124	B. WING				C / 26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER	•	439	EET ADDRESS, CITY, STATE, ZIP CODE BELLEVUE AVENUE ENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
E 004 SS=D	Appendix Z-Emerge Provider and Supplion Guidance 483.73, R Care (LTC) Facilities	substantial compliance with ency Preparedness for All er Types Interpretive lequirements for Long Term s. eview and Update Annually	E(004			8/25/24
33 2	§403.748(a), §416.5	34(a), §482.15(a), §483.73(a), 02(a), §485.68(a), 325(a), §485.727(a),					
	Federal, State and le preparedness required develop establish ar emergency prepared requirements of this	rements. The [facility] must and maintain a comprehensive dness program that meets the section. The emergency am must include, but not be					
	and maintain an em that must be [review	. The [facility] must develop ergency preparedness plan red], and updated at least plan must do all of the					
	CAH] must comply v State, and local eme requirements. The l develop and maintai	gency Plan. The [hospital or with all applicable Federal, ergency preparedness [hospital or CAH] must					
LABORATORY	 DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNATUI	RE		TITLE		(X6) DATE

Electronically Signed 07/24/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _				C / 26/2024	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		<u>, </u>	20,2024	
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E 004	Plan. The LTC facility an emergency prepareviewed, and updated * [For ESRD Facilitie Plan. The ESRD facilities Plan. The Esrd plan interview at Emergency Prepared (EPP), it was determined that their EPF at least annually. This deficient practice following: On 6/24/24 at 1:03 Prepared that the program was to be reasked if there was a that the program was that there was none prepared to the expension of the EUS FOIA (b)(6) program was that there was none prepared to the expension of the EUS FOIA (b)(6) program was that there was none prepared to the expension of the EUS FOIA (b)(6) program was that there was none prepared to the expension of the EUS FOIA (b)(6) program was that there was none prepared to the expension of the EUS FOIA (b)(6) program was that there was none prepared to the expension of the EUS FOIA (b)(6) program was that there was none prepared to the expension of the EUS FOIA (b)(6) program was that there was none prepared to the expension of the EUS FOIA (b)(6) program was that there was none prepared to the expension of the EUS FOIA (b)(6) program was that there was none prepared to the expension of the EUS FOIA (b) (c) program was the expension of the EUS FOIA (b) (c) program was the expension of the EUS FOIA (b) (c) program was the expension of the EUS FOIA (b) (c) program was the expension of the EUS FOIA (b) (c) program was the expension of the EUS FOIA (b) (c) program was the expension of the EUS FOIA (c) (c) program was the expension of the EUS FOIA (c) (c) program was the expension of the EUS FOIA (c) (c) program was the expension of the EUS FOIA (c) (c) program was the expension of the EUS FOIA (c) (c) program was the expension of the EUS FOIA (c) (c) program was the expension of the EUS FOIA (c) (c) program was the expension of the EUS FOIA (c) (c) program was the expension of the EUS FOIA (c) (c) program was the expension of the	at §483.73(a):] Emergency must develop and maintain redness plan that must be ed at least annually. Is at §494.62(a):] Emergency lity must develop and review of the facility's dness Plan and Program and review of the facility failed to a was reviewed and updated In the US FOIA (b)(6) and the US FOIA (b)(6) at they were both werall completion and confirmed that their eviewed annually. When signature page documenting is reviewed, the userous was review, a	E	El¿ The Ma of t pla El¿ All affe El¿ On the imp upo pre Adı pre	ment 1 e Administrator and Director of intenance initiated a review and up the facility emergency preparednes in, ment 2 residents have the potential to be exted by this practice. ment 3 7/29/24 the Administrator inservices US FOIA (b)(6) as to the potential to the potential to the potential to be extend by this practice. The portance of reviewing annually and dating the facility emergency eparedness plan at least annually. The potential to the potential to the portance of reviewing annually and dating the facility emergency eparedness plan at least annually. The potential to the potential to the potential to the potential to the the facility emergency eparedness plan on a quarterly for the total the the emergency preparedness determine compliant that the emergency preparedness.	ed , he ce		
		ontract" was located in the 2022, with a previous a identified.		Ele	n is up to date. ement 4 e results of the quarterly audits will	be		

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E 004	was reviewed and up In a facility provided of Management Plan," v date of April 2024, ind team represented as conduct annual evalu Management Plan. To review and assessment scope, performance, NJAC 8:39-31.2(e).	FOIA (b)(6) le evidence that their EPP dated annually. document titled, "Emergency with a handwritten revised cluded: a multidisciplinary The Safety Committee will ation of the Emergency the evaluation will include ent of the plan's objectives,		0004	submitted to the Quality Assurance and Process Improvement Committee Mee quarterly for 1 year. Based on the resu of these audits, a decision will be made regarding the frequency of submission and reporting.	ting ılts	8/25/24	
SS=D	CFR(s): 483.73(a)(1)-(2), § §403.748(a)(1)-(2), § §418.113(a)(1)-(2), §460.84(a)(1)-(2), §4(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.920(a)(1)-(2), §491.12(a)(1)-(2), §491.12(a)(2), §491.12(a)(2), §491.12(a)(2), §491.12(a)(2), §491.12(a)(2), §491.12(a)(2), §491.12(a)(2), §491.12(a)(2),	16.54(a)(1)-(2), 141.184(a)(1)-(2), 182.15(a)(1)-(2), §483.73(a) 1-(2), §484.102(a)(1)-(2), 185.542(a)(1)-(2), 186.360(a)(1)-(2), 186.360(a)(1)-(2), 194.62(a)(1)-(2) The [facility] must develop regency preparedness pland, and updated at least every ust do the following:]					O. 20, 2	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
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E 006	* [For Hospices at § The Hospice must emergency prepare reviewed, and upda plan must do the for (1) Be based on an facility-based and cassessment, utilizing (2) Include strategic events identified by including the mana of power failures, in emergencies that we ability to provide cate [For LTC facilities] Plan. The LTC facilities Plan. The LTC facilities Plan. The LTC facilities an emergency prepareviewed, and update must do the following (1) Be based on an facility-based and cassessment, utilizing including missing recovered (2) Include strategic events identified by the ICF/IID sat §4 The ICF/IID must demergency prepared	A the risk assessment. S418.113(a):] Emergency Plan. develop and maintain an edness plan that must be ated at least every 2 years. The office of the community-based risk and an all-hazards approach. The risk assessment, gement of the consequences atural disasters, and other would affect the hospice's are. Lat §483.73(a):] Emergency ity must develop and maintain paredness plan that must be ated at least annually. The plan and include a documented, community-based risk and an all-hazards approach, residents. Les for addressing emergency of the risk assessment. Les for addressing emergency of the risk assessment.	E	006				
	facility-based and o	d include a documented, community-based risk ng an all-hazards approach,						

	OF DEFICIENCIES CORRECTION	I DENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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E 006	events identified by This REQUIREME by: Based on interviee Emergency Prepar (EPP), it was detendevelop an EPP use This deficient prace following: On 6/24/24 at 1:03 confirmed responsible for the maintenance of the hazards were idented assessment, the gas, electrical, etc. Where any addition the EPP and state. The surveyor obset form was blank. The weather elements included in the EP they were not included in the EP they were not included in the EP they were not included an all hazards assessment, the completed. In a facility provide Management Planted of April 2024, Performance of Plantalysis (HVA)- All	- -	E	E006- pending copy of risk El¿ment 1 On 6/28/2024 the Director of initiated developing an emergreparedness plan using at approach. El¿ment 2 All residents have the poter affected by this practice. El¿ment 3 On 7/29/24 the Administrate the US FOIA (b)(6) importance of developing a preparedness plan using at approach. Administrator will audit the preparedness plan on a quest 4 quarters to determine if the date including an all-hazard El¿ment 4 The results of the audits with to the Quality Assurance are Improvement Committee Morent for 1 year. Based on the reaudits, a decision will be more the need for continued subtreporting.	of Maintenariergency n all-hazards ntial to be tor in-service as to the an emergency larterly basis he plan is up ds approach ill be submitt nd Process feeting mont esults of the lade regardir	ed sy s for to to thly se		

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E 006	Continued From page	: 5	E	006			
E 007 SS=D	NJAC 8:39-31.2(e) EP Program Patient F CFR(s): 483.73(a)(3)		E	007		8/25/24	
	§441.184(a)(3), §46 §483.73(a)(3), §483.4 §485.68(a)(3), §485.5	.54(a)(3), §418.113(a)(3), 0.84(a)(3), §482.15(a)(3), 175(a)(3), §484.102(a)(3), 142(a)(3), §485.625(a)(3), 920(a)(3), §491.12(a)(3),					
	and maintain an eme	The [facility] must develop rgency preparedness plan d, and updated at least every st do the following:]					
	but not limited to, perservices the [facility] han emergency; and co	lient] population, including, sons at-risk; the type of nas the ability to provide in ontinuity of operations, of authority and succession					
	Plan. The LTC facility an emergency prepar reviewed, and update plan must do all of the (3) Address resident limited to, persons at- LTC facility has the all emergency; and conti	population, including, but not risk; the type of services the pility to provide in an					
	*NOTE: ["Persons at hospice, PACE, HHA	risk" does not apply to: ASC, , CORF, CMCH,					

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE			
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E 007	Based on interview Emergency Prepare (EPP), it it was dete to ensure the Emergency Prepare (EPP), it it was dete to ensure the Emergency Prepare (EPP), it it was dete to ensure the Emergency and policient populations. This deficient practiful following: On 6/24/24 at 1:03 Onfirmed in responsible for the maintenance of the were any special policient and stated that the and placed in a bus resident, the "similar process" as When asked if the and placed in a bus resident, the anyone additional has the evacuation of when asked if the Equipment of the evacuation of	RD facilities.] AT is not met as evidenced A and review of the facility's edness Plan and Program ermined that the facility failed gency Plans included a plan and staff would address the needs during an emergency. The ce was evidenced by the PM, th US FOIA (b)(6) That they were both overall completion and EPP. When asked if there opulations in the facility, the ley have where in here from the facility in case of an attention and the rest of the population. The could be evacuated with a could be evacuated with a could be evacuated at the rest of the population. The could be evacuated in regards of the population and the facility in case of an attention and the facility in case of an attention and the rest of the population. The could be evacuated at the rest of the population. The could be evacuated at the rest of the population. The could be evacuated at the rest of the population. The could be evacuated at the rest of the population. The could be evacuated at the rest of the population. The could be evacuated at the rest of the population. The could be evacuated at the rest of the population. The could be evacuated at the rest of the population. The could be evacuated at the rest of the population. The could be evacuated at the rest of the population. The could be evacuated at the rest of the population. The could be evacuated at the rest of the population. The could be evacuated at the rest of the population at the rest of the population. The could be evacuated at the rest of the population at the rest of the populati	EC	E007 Element 1 The Director of Maintenan initiated updating the facility preparedness plan to include how the facility and staff we patient populations included limited to staff control of the potential and the	ity emergency ude a plan for would address ing but not not not plan for ing an ential to be istrator (b)(6) witing the facility and staff wou ation needs e emergency puarterly basis ompliance with a emergency. It is plan to include and staff wou ation needs e emergency puarterly basis ompliance with a emergency. It is audits will be second on the result will be made in will be made	as y de ld sfor th		

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION G	COMPLETED		
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	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	, 30/20/21		
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E 007	populations identifie NJAC 8:39-31.2(e)	lid not address the special d in the facility.	E 0				
E 009 SS=D	Local, State, Tribal (CFR(s): 483.73(a)(4) §403.748(a)(4), §41 §441.184(a)(4), §46 §483.73(a)(4), §485 §485.68(a)(4), §494 [(a) Emergency Plar and maintain an em that must be review 2 years [annually for do the following:] (4) Include a process collaboration with lo Federal emergency to maintain an integrity disaster or emergen * [For ESRD facilitie Include a process for collaboration with lo Federal emergency to maintain an integrity disaster or emergen facility must contact preparedness agency that the agency is an needs in the event of the second state of	6.54(a)(4), §418.113(a)(4), 0.84(a)(4), §482.15(a)(4), .475(a)(4), §484.102(a)(4), .542(a)(4), §486.360(a)(4), .5920(a)(4), §486.360(a)(4), .62(a)(4) n. The [facility] must develop ergency preparedness plan ed, and updated at least every r LTC facilities]. The plan must so for cooperation and cal, tribal, regional, State, and preparedness officials' efforts rated response during a cy situation. * s only at §494.62(a)(4)]: (4) or cooperation and cal, tribal, regional, State, and preparedness officials' efforts rated response during a cy situation. The dialysis the local emergency cy at least annually to confirm ware of the dialysis facility's	EO	09	8/25/24		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315124	B. WING				C 26/2024
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BELLE CA	RE NURSING AND REH	ABILITATION CENTER			RENTON, NJ 08618		
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E 009	Continued From page	÷ 8	E	009			
E 009	Based on interview a Emergency Prepared (EPP), it was determinensure that a copy of local and county office management (OEM). This deficient practice following: On 6/24/24 at 1:03 Plant on firmed the responsible for the own maintenance of the EUS FOIA (b)(6) was to be reviewed a local and county OEM mail. At this time, the documentation that the with or acknowledged required. In a facility provided of Management Plan, we date of April 2024, including the maintenance of the EUS FOIA (b)(1).	and review of the facility's ness Plan and Program ned that the facility failed to the EPP was sent to the e of emergency for annual review. The was evidenced by the ewas evidenced by the was evidenced by the evall completion and PP. The evaluation and confirmed that the program nnually and forwarded to the evidence to the evidence of the EPP as evidence to the EPP as evidence to the EPP as evidence a multidisciplinary. The Safety Committee will atton of the Emergency ne evaluation will include ent of the plan's objectives,	E	009	E009 Element 1 The Director of Maintenance will send copy of the emergency preparedness process to the local and county office of emergency management by 8/25/24 for annual review. A copy of the cover letter sent to each OEM office will be submitted via EPOC acknowledgment. Element 2 All residents have the potential to be affected by this practice. Element 3 On 7/20/2024 The Administrator in-serviced the US FOIA (b)(6) to the importance of sending a copy of emergency preparedness plan to the location and county office of emergency management for annual review. The Administrator will audit the emergency management plan on a quarterly basis for 4 quarters to ensure compliance with all required information Element 4 The results of the quarterly audits will be submitted to the Quality Assurance and Process Improvement Committee Mee quarterly for 1 year. Based on the result of these audits, a decision will be made regarding the frequency of submission	as the ocal	
	NJAC 8:39-31.2(e).	and ellectivelless.			and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on Aug 1 2024.	gust	
F 000	INITIAL COMMENTS		F	000			
	Complaint #: NJ1593	377, NJ159451, NJ159539,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ABILITATION CENTER	-	4	TREET ADDRESS, CITY, STATE, ZIP CODE 39 BELLEVUE AVENUE RENTON, NJ 08618		20/2027
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F 000 F 550 SS=D	NJ166562, NJ166768 NJ174454 Survey Date: 6/26/24 Census: 94 Sample: 32 + 3 A Recertification Surved termine compliance Requirements for Lor Deficiencies were cite Resident Rights/Exer CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a rig self-determination, an access to persons and	yey was conducted to e with 42 CFR Part 483, ng Term Care Facilities. ed for this survey. cise of Rights (2)(b)(1)(2) Rights. ght to a dignified existence, and communication with and		550	DELIGITION)		8/25/24
	with respect and dign resident in a manner promotes maintenand her quality of life, reco- individuality. The faci promote the rights of §483.10(a)(2) The faci access to quality care	and in an environment that the or enhancement of his or tognizing each resident's lity must protect and the resident. cility must provide equal the regardless of diagnosis,					
	must establish and m practices regarding tr	or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDII			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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F 550	rights as a resident or resident of the Unsupersident can exercise interference, coerciofrom the facility. §483.10(b)(2) The refree of interference, reprisal from the facility and to be supersided by: Complaint NJ #: 158 Based on observation pertinent facility document facility failed that promoted maint the resident's was identified for 1 or Resident Rights (Resident Rights (Resident #60 in their	of Rights. a right to exercise his or her of the facility and as a citizen lited States. acility must ensure that the e his or her rights without on, discrimination, or reprisal esident has the right to be coercion, discrimination, and lity in exercising his or her ported by the facility in the rights as required under this T is not met as evidenced 2451; 159783 In interview, and review of the uments, it was determined to maintain an environment enance or enhancement of the residents reviewed for	F	550	F550 Element 1 On 6/26/2024 The Environmental Services Director initiated a of resident #60 s room to include of the entire room on 7/24/2024 The Administrator and UManager for Resident #60 offered resident to NJ Exec Order 26.4b1 within the facility. NJ Exec Order 26.4b1. The Administrator and Environmental Services Director reviewed and update the facility policy on resident s rights the ensure it is compliant with maintaining resident s dignity and care by 8/25/20	n. Init ed o a		
		oom because their roommate			Element 2 All residents have the potential to be affected by this practice.			

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	ROVIDER OR SUPPLIER ARE NURSING AND REI	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618				
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F 550	Resident #60 confirm On 6/20/24 at 10:52 Nulexec Order 26:453 nursin while a room. The surveyor the floor by Resident in addition to on the bed. Upon ex observed two facility across from the resid conversation. On 6/20/24 at 11:41 that Registered Nurs Resident #60's room room, RN #1 acknow and confirmed room's condition app to the surveyor being that they notified hot certified nursing aide stated that they were was rectified. On 6/20/24 at 11:55 the US FOIA (b)(stated that considered as the re stated that Resident a room that entire hallway by Re and that the tw sitting in the alcove s identify the location of	AM, the surveyor was on the gunit and NJ Exec Order 26.451 pproaching Resident #60's entered the room to discover at #60's bed was and observed iting the room, the surveyor staff sitting in the alcove dent's room engaged in AM, the surveyor requested se (RN #1) walk with them to a. While approaching the wiedged the NJ Exec Order 26.451 that they were aware of the proximately 30 minutes prior gon the floor. RN #1 stated usekeeping and instructed the est to clean the room. RN #1 e under the impression that it AM, the surveyor interviewed as the the rooms were to be sident's home. The NS FOIA (DIS) at the rooms were to be sident's home. The NS FOIA (DIS) #60 should not have to sit in	F	550	Element 3 The Environmental Service Director wil initiate staff re-education of residents rights to an environment that promotes the maintenance or enhancement of the resident squality of life for all housekeeping and laundry staff. The Administrator and Environmental Services Director reviewed and update the facility policy on resident rights to ensure it is compliant with maintaining resident dignity and care. The Environmental Services Director we conduct a weekly audit of 5 rooms of the total resident census weekly times four weeks. When compliance is determined the facility will continue to audit 5 room the total resident census monthly for the next six (6) months with results submitted to the QAPI Committee. Element 4 The results of the weekly and daily audit will be submitted to the Quality Assurar and Process Improvement Committee Meeting monthly for 6 months. Based the results of these audits, a decision were made regarding the need for continus submission and reporting.	e d o a vill ne c(4) d, s of e ded o o o vill		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED	
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F 550	A review of the mos Data Set (MDS), an Status (BIMS) score indicated a NJ Exection to receive the US FOIA (b)(resident room should timely fashion and the expectation to receive the US FOIA (b)(resident room should the expectation to receive the US FOIA (b)(resident room should the expectation to receive the US FOIA (b)(resident room should the expectation to receive the US FOIA (b)(resident room should the expectation to receive the US FOIA (b)(resident room should the expectation to receive the US FOIA (b)(resident room should the expectation to receive the US FOIA (b)(resident room should the expectation to receive the US FOIA (b)(resident room should the expectation to receive the use of the	ission Record face sheet (and) reflected that resident was sty with diagnosis that Order 26.4b1 C Order 26.4b1 C Order 26.4b1 All trecent quarterly Minimum assessment tool dated brief interview for mental of the out of 15, which conder 26.4b1 All the surveyor interviewed (a) who stated that the diagnost have been cleaned in a nat residents should have the we quality care and quality All the US FOIA (b)(6) in the presence of	F 5			
	Resident #60's room the resident to discu- condition impacted to A review of the facili- created 2/2024, incliring to a safe, clear Environment, include	n, but have never approached uss whether or not this living				

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F 550	A review of the facility Homelike Environme facility staff and manathe extent possible, the facility that reflect a property setting. These characters cleanliness and orders scents A review of the facility Aide Position" documentate residents and far quality of service in a atmosphere which reneeds and right A review of the facility Practical Nurse Positions state and federal regresidents and families of service in a caring atmosphere which reneeds and right A review of the facility of service in a caring atmosphere which reneeds and right A review of the facility Nurse Position" documents and coordinates and coord	y's undated "Quality of Lifent" policy included2. The agement shall maximize, to the characteristics of the ersonalized, homelike eteristics include: a. re. Pleasant, neutral y's undated "Certified Nurse then included22. Ensures milies receive the highest caring and compassionate cognizes the individuals' y's undated "Licensed ion" document included9. dinates nursing personnel in the ent care in adherence with culations. 10. Ensures that is receive the highest quality and compassionate cognizes the individuals' y's undated "Registered ment included2. 9. dinates nursing personnel in the ent care in adherence with undates received the highest quality and compassionate cognizes the individuals'	F 55			
F 573 SS=D	CFR(s): 483.10(g)(2) §483.10(g)(2) The re	hase Copies of Records	F 57	3	8/25/24	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 573	access to personal pertaining to him of written request, in by the individual, if form and format (ir or format when sure electronically), or, form or such other by the facility and to (excluding weeken (ii) The facility must copy of the records (including in an elessuch records are not request and 2 world facility. The facility cost-based fee on provided that the formal (A) Labor for copy the individual, where (B) Supplies for creelectronic media if electronic copy be and (C)Postage, when the copy be mailed \$483.10(g)(3) With described in paragisection, the facility is provided to each the resident can act including in an alter that the resident cat translate information.	t provide the resident with and medical records reself, upon an oral or the form and format requested it is readily producible in such acluding in an electronic form the records are maintained if not, in a readable hard copy form and format as agreed to the individual, within 24 hours do and holidays); and at allow the resident to obtain a sor any portions thereof actronic form or format when maintained electronically) upon king days advance notice to the may impose a reasonable, the provision of copies, the provision of copies, the includes only the cost of: and the records requested by ther in paper or electronic form; the individual requests that the provided on portable media; the individual has requested	F	573			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 573	Continued From page	e 15	F 5	573			
	patient at their request accordance with appl This REQUIREMENT by: NJ Complaint #1688	icable law. is not met as evidenced			Element 1: The facility was unable to locate requested records for resident #252.		
	Based on interviews and review of pertinent facility documents, it was determined that the facility failed to provide a discharged resident with a copy of their medical records within a timely manner of the written request. This deficient practice was identified for 1 of 1 resident reviewed for medical records (Resident #252), and was evidenced by the following: According to the Resident Face Sheet (an				Resident #252 representative was una to be notified due to no contact information on the facesheet. The Administrator will conduct in-servi and education based on the findings in this deficiency to ensure that going forward a copy of the record will be furnished within 2 working days. The Administrator / Designee will cond an audit to assure that no other medical	ce	
	admission summary) admitted to the facility NJ Exec Order 25.4b1. The faresident's discharge of A review of the electrons.	with diagnoses with diagnoses are sheet did not include the date. onic Admissions record 52 was discharged from the			record requests are currently outstandi to include a date the request was initia and completed and by whom. Element 2 All residents have the potential to be affected by this practice. Element 3 The Administrator and Medical Record	ng, ted	
	the Medical Records residents and authori medical records. One personnel received the out the medical recorreview to ensure they accurate. At that time Medical Records persif she could provide decords were request	e the surveyor provided the sonnel with a list of residents locumentation if medical ed.			Coordinator will conduct a review and revise where needed the facility Medic: Records Request policy to ensure each resident access to their personal medic record within twenty-four (24) hours, ar copies within forty-eight (48) hours of the date requested. The Administrator / Designee will cond in-service education with all Medical Records, Unit Clerks, and Reception son the facility policy and procedure for Access/ Documentation to Medical Records Requests.	n cal nd he uct	
	On 6/20/24 at 9:12 A	M, the Medical Records			The Medical Records Coordinator /		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 573	a representative for copy of the resider Medical Records provided US FOIA (b)(6) and them to the representation them to the representation of the medical records representative for the receive a copy of records. On 6/25/24 at 10:3 the service with a small records with a small records.	d the surveyor that months ago or Resident #252 requested a nt's medical records. The personnel stated she had made ed them to the previous she was unsure if he sent entative for Resident #252. At eyor requested a copy of the equest and any documentation as were released. Cumentation provided by the (b)(6) hat on (b)(6) hat on (c)(6)	F	573	Designee will conduct weekly audits of medical record requests weekly times a weeks. When compliance is established the facility will continue auditing all medical record requests monthly for the next six (6) months. Element 4 The results of the weekly and daily audition will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based the results of these audits, a decision who be made regarding the need for continus submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on August 1, 2024.	B d e lits nce on vill ued	

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F 573	Continued From page	e 17	F	573			
F 580 SS=D	NJAC 8:39-35.2(h) Notify of Changes (In CFR(s): 483.10(g)(14	jury/Decline/Room, etc.))(i)-(iv)(15)	F	580			8/25/24
	consult with the resid consistent with his or representative(s) who (A) An accident involves accident involves and injury and his physician intervention (B) A significant chan mental, or psychosocideterioration in health status in either life-the clinical complications (C) A need to alter trea need to discontinue treatment due to advect commence a new for (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informatic is available and proviphysician. (iii) The facility must a resident and the resident and the resident and the resident as specified in §483.1. (B) A change in resident in resident and the	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring a; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial reatening conditions or); eatment significantly (that is, a an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the lent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED	
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F 580	update the address (phone number of the representative(s). §483.10(g)(15) Admission to a compthat is a composite d §483.5) must disclosits physical configural locations that compripart, and must specif room changes between under §483.15(c)(9). This REQUIREMENT by: Complaint NJ #1621 Based on interviews, records, and pertiner determined that the fresident's family after deficient practice was sampled residents (Fevidenced by the followed admitted to the facility from the facility in	record and periodically mailing and email) and resident resident	F 5	,	nedical conducted acility mily after ere not sident□s of ucation to fy the nsible in		
	assessment tool date resident had NJ Exec Or	ed Nutrocome, indicated that the der 26.4b1 and Nutrocomers and noses which included		This will be completed by July 30 On July 25, 2024, The Director of Nurses/Designee will initiate an identify any incident reports in the month in which families and/or	0, 2024. of audit to		

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F 580	A review of the Progr Note (NN) dated noted NJ Exec Ord Vital signs w resident NJ Exec Ord wheelchair NJ Exec Ord their	ress Notes included a Nurses of the surveyor interviewed family was notified anytime order 26.4b1. The surveyor there was no phone number epresentative, and the surveyor the surveyor the surveyor there was no phone number epresentative.	F	580	responsible party were not notified. Thi will be completed by July 26, 2024. On July 23, 2024, The Admission Director/Designee initiated an audit for residents to ensure there is a phone number in the medical record. This aud will be completed by July 26, 2024. Element 2: Identification of at-Risk Area All residents have the potential to be affected by this practice. Element 3: Systemic Change On July 25, 2024, The Director of Nurses/Designee initiated re-education the licensed nursing staff and agency licensed nursing staff in the facility on the Policy and Procedure for notifying responsible party and/or family member of changes in condition. The Director of Nursing/designee will audit 5 random resident charts to assurt that the responsible party and/or family have been notified of the residents change in condition weekly times four (all dit as to he ers	
	On 6/20/24 at 12:57 PM, the survey team met with the US FOIA (b)(6), and requested any additional information on Resident #247's notification. The stated that the resident had a responsible party who was very involved, and needed to check the Progress Notes. The surveyor requested a change of condition policy.				then and after the 4-weeks and competency is established, the facility of continue auditing 3 charts monthly for 2 quarter to monitor for compliance and report to QA. Element 4: Monitoring/ Quality Assurant The results of the weekly and daily auditing auditing auditing and the second secon	will one rs	

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s m sith T h ne pre N N N F 582 SS=E S (i) w fa c s (i) c s s s S	and survey teal poke to Resident #2- nember via the teleple eparate book, and the responsible party confirmed ave been located in ecord, and that Resident's NJ Exec Ordinary should have been located in ecord, and that Resident's NJ Exec Ordinary should have been located in ecord, and that Resident's NJ Exec Ordinary should have been located in locate	the US FOIA (b) (6) the presence of the usually the stated that she usually the stated that she usually the stated that she stored in a stated that she should the phone number should the resident's medical that the stated that she should the stated that she should the stated that she should that s		580	will be submitted to the Quality Assurar and Process Improvement Committee Meeting monthly for 6 months. Based the results of these audits, a decision was be made regarding the need for continusubmission and reporting.	on vill	8/25/24

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F 582	available in the facility services, including covered under Medacility's per diem r (i) Where changes and services cover Medicaid State planotice to residents reasonably possib (ii) Where changes items and services facility must inform 60 days prior to im (iii) If a resident die transferred and do facility must refunct representative, or deposit or charges per diem rate, for the resided or reserved facility, regardless discharge notice re (iv) The facility must refunct representative in the resident within date of discharge for the resident within date of discharge for these regulations. This REQUIREME by: Based on interview facility documents,	the resident's stay, of services sility and of charges for those any charges for services not dicare/ Medicaid or by the rate. in coverage are made to items red by Medicare and/or by the n, the facility must provide of the change as soon as is le. Is are made to charges for other that the facility offers, the offers that the facility offers, the offers is hospitalized or is less or is hospitalized or is less not return to the facility, the offers that the resident, resident lestate, as applicable, any laready paid, less the facility's lestate, as applicable, any lestate, as applicable and lestate of any minimum stay or lequirements. It is refund to the resident or leading and all refunds due and days from the resident's from the facility. In admission contract by or on local seeking admission to the noffict with the requirements of leading admission to the noffict with the requirements of leading admission to the noffict with the requirements of leading admission to the noffict with the requirements of leading admission to the noffict with the requirements of leading admission to the noffict with the requirements of leading admission to the noffict with the requirements of leading admission to the noffict with the requirements of leading admission to the noffict with the requirements of leading admission to the noffict with the requirements of leading admission to the noffict with the requirements of leading and leading admission to the noffict with the requirements of leading and leading a	F	582	Element 1 Resident # 28 has Resident #55 was notified on by the administrator/designee with the appropriate JEXOTO and LEXCOTOUT 25.41 Resident # 82 was notified on RESIDENT TO THE RESIDENT		

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	Continued From page practice was identifier reviewed for beneficia #28, #55, and #82), a following: On 6/25/24 at 9:18 A three residents (#28, discharged from their benefit days remaining and should have recently as a facility benefit days were nownot have the resident sign the required the NJ Exec Order also unsigned and days are also unsigned and days were nownot have the resident sign the required the NJ Exec Order also unsigned and days were nownot have the resident sign the required the NJ Exec Order would not costs. Resident #55 had a lay of NJ Exec Order 26.4b1 see NJ Exec Order 2	e 22 d for for 3 of 3 residents ary notifications (Resident and was evidenced by the	TAG		CROSS-REFERENCED TO THE APPRO DEFICIENCY)	e n. e view v policy re ly as it of and forms o vices. nduct s y are ce of ee will nced times	
	provided the or with a not incorrect; it was signed after the laform was also signed services with n costs. The	form for the resident to sign ation that the date was			The Administrator will continue to at Notice of Medicare Non-Coverage (NOMNC) and Advanced Beneficiar Notice (ABN) for the next six (6) mo to monitor compliance and report Q Committee. Element # 4 The results of the weekly and daily will be submitted to the Quality Assu	y nths API audits	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVE' COMPLETED	
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F 582	Resident #82 had a lof NJ Exec Order 26.4b1 set the resident NJ Exec Order 26.4b1. The second form for the which the facility note and responsible signature. The dated NJ Exec Order 26.4b1 and o with no documented form contained no ot not cover with the es On 6/25/24 at 10:01 the US FOIA (b) (6 who stated the were provided to resident their right to NJ Exec Order 26.4b1 services were discharge from refresident their right to NJ Exec Order 26.4b1 services we cost of those services reviewed the resident and the services we cost of those services reviewed the resident and the services we cost of those services reviewed the resident and the services we cost of those services reviewed the resident and the services we cost of those services reviewed the resident and the services we cost of those services reviewed the resident and the services we cost of those services reviewed the resident and the services we cost of those services reviewed the resident and the services we cost of those services we cost of those services reviewed the resident and the services we cost of those services reviewed the resident and the services we cost of those services reviewed the resident and the services we cost of those services we cost of th	ast documented covered day ervice date of the resident to sign on the resident to services to services the reservices to services the reservices to services the reservices to service the reservices to service to the services to service to the resident to service to the services to service to the services to service to servi	F 5	and Process Improvement Co Meeting monthly for 6 months the results of these audits, a co be made regarding the need if submission and reporting.	s. Based on decision will	

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		315124	B. WING _		00	C 5/26/2024
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 582	revised 1/1/24, include a timely manner and Beneficiary Notices (Amedicare Non-Cover for Medicare Non-Cover for Medicare Medicare [Minimum Data Set] (for monitoring and encompleted on each remannerABN is issue Medicare to deny pay because it is not reast Medicare Program state beneficiary to man about whether to get financial responsibility Medicare does not paissuance of ABN and the notice is [] provious of potentially non-covallow sufficient time for available options (at beneficiary or the bermust sign and retain the signed ABN to yo beneficiary's record. ABN on file while awa ABN. If the beneficiar copy, document the insubsequent attempts appropriate records of NJAC 8:39-5.4 (b)(c)	otice of Medicare NC) Guidelines" dated last ed the facility shall obtain in retain all Advance ABN) and Notice of age as required by [Centers e Services] guidelines. The Coordinator is responsible suring the ABN's are esident in a timely ed when you expect yment for an item or service onable and necessary under andardsThe ABN allows ke an informed decision services and accept y for those services if ayMedicare considers /or NOMNC effective when ded far enough in advance ered items or services to or the beneficiary to consider east two days)The neficiary's representative the ABN and send a copy of u for retention in the Keep a copy of the unsigned aiting receipt of the signed by fails to return a signed intial contact and to obtain a signature in or on the ABN.	F 5			
F 584 SS=D		. ,	F 5	84		8/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _				C 26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		439	REET ADDRESS, CITY, STATE, ZIP CODE 9 BELLEVUE AVENUE RENTON, NJ 08618	1 00/	20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From page	e 25	F 5	584			
	The resident has a ric comfortable and hom but not limited to rece supports for daily living	elike environment, including eiving treatment and					
	homelike environmer use his or her person possible. (i) This includes ensureceive care and serve physical layout of the independence and do (ii) The facility shall e	ride- clean, comfortable, and nt, allowing the resident to hal belongings to the extent ring that the resident can rices safely and that the facility maximizes resident hes not pose a safety risk, exercise reasonable care for resident's property from loss					
		eeping and maintenance o maintain a sanitary, orderly, rior;					
	§483.10(i)(3) Clean b in good condition;	ped and bath linens that are					
	§483.10(i)(4) Private resident room, as spe	closet space in each ecified in §483.90 (e)(2)(iv);					
	§483.10(i)(5) Adequal levels in all areas;	ate and comfortable lighting					
	levels. Facilities initia	table and safe temperature lly certified after October 1, a temperature range of 71 to					
	§483.10(i)(7) For the sound levels.	maintenance of comfortable					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			06/3	26/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE		20/2024
				439 BELLEVUE AVENUE			
BELLE CA	ARE NURSING AND RE	EHABILITATION CENTER		TRENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 584		ige 26 NT is not met as evidenced	F 5	i84			
	other facility documentate the facility failed environment, equip safe, sanitary, and clean linens and propractice was identifed observed for the facility of the facility	ion, interview, and review of mentation, it was determined d to to maintain the residents' ment, and living areas in a homelike manner that included ivacy curtains. This deficient fied for 2 of 2 nursing units cility environment task. ice was evidenced by the conference on 6/17/24 at eyor asked what the resident y was, and the was evidenced by the in the stated 2 AM, during initial tour of the ng unit, the surveyor observed cart located near Resident contain any towels. 3 AM, the surveyor toured the ng unit and observed no clean linen cart located by Resident e clean towel in the clean linen		F584 Element 1. The Environmental Service secure sufficient linen to more need on all shifts. Bedside curtain in room 34 on 6/20/2024. All resident privacy curtains assessed for cleanliness at were addressed. On 06/26/24 the environment director conducted an audit and privacy curtains to dete adequate PAR levels to me needs. The Environmental Service initiated the usage of an enstock of all facility linens an curtains to ensure that in the emergency the facility is abla a safe, clean, comfortable, environment. Element 2 All residents have the poter impacted by this deficient pelement 3 The Environmental Service Designee will initiate re-edu housekeeping and laundry protocol for proper notificat documentation of the review for maintaining a safe, clean and homelike environment facility forms with specific esufficient stocking of all lines the facility, the use of clean curtains, and the location of	was changed is was changed is were and any finding the central services it on linen store it on and privacy in event of an olde to maintain homelike it on the store it on and it is taff on the store it on and it is we of the police it is within the emphasis on en carts within in privacy	ed logs s bock ck n in	

CENTER	3 FOR MEDICARE &	MEDICAID SERVICES				CIVID INC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	1	LETED
		315124	B. WING				C 26/2024
		010124				1 06/	26/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BELLEC	ARE NURSING AND REH	IABII ITATION CENTED		43	39 BELLEVUE AVENUE		
BELLE CA	ARE NORSING AND REF	ABILITATION CENTER		T	RENTON, NJ 08618		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	Χ	(EACH CORRECTIVE ACTION SHOULD B		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	ATE	DATE
					DEFICIENCY)		
F 584	Continued From page	e 27	F	584			
	On 6/24/24 at 1:39 P	M, the surveyor interviewed			emergency linens stock.		
	the US FOIA (b)(6) who stated			The Environmental Services Director/		
		s were routinely processed			Designee will conduct weekly for 4 week	eks	
		The indicted that there			and monthly for 3 months an audit on a		
	, ,	where clean towels were			linen carts to ensure the facilities policy		
	_	e residents. The surveyor			and procedure for maintaining a safe,		
		tion of the laundry room,			clean, comfortable, homelike environm	ent	
	1	ed that only six towels were			with great emphasis on sufficiently		
	clean. At that time, H			stocked linen .			
		oom and stated that they			The facilities Environmental/Designee	will	
	were responsible for			audit five (5) resident rooms regarding			
		s. When asked the times in			proper condition of privacy curtains of	he	
		ought to the floors, HK #1			total resident census weekly times four		
		brought up at 7:30 AM			Once compliance is established, the	•	
	1	1:30 PM, and about 2:30 to			facility will continue to audit 5 resident		
	1	of shift. When asked how			rooms monthly for three (3) months to		
		ought to the floor, HK #1			monitor compliance and report QAPI		
		•			Committee.		
		Is and twenty washcloths. aned if there were any issues			Element4		
						dita	
		els, at which time HK #1			The results of the weekly and daily aud		
		lity can run low because the			will be submitted to the Quality Assuran	ice	
	•	away a lot of the towels and			and Process Improvement Committee		
	washcloths.				Meeting monthly for 4 months. Based		
	0:- 0/05/04 -+ 44:40	A.B.A. 41			the results of these audits, a decision v		
		AM, the surveyor interviewed			be made regarding the need for contin	uea	
	the US FOIA (b)(6				submission and reporting.		
	who acknowle						
		d identified that the number					
	of towels "has gone of						
		s "were a problem" and that					
		d an order for additional					
	towels.					ĺ	
	On 6/26/2024 at 10:3	S5 AM the USFOIA (D)(G) in the				I	
	presence of the US						
	that there was used	, and confirmed					
	I .	ough towels in the facility for					
		t morning they stopped at a					
	sister facility to pick ι	ıp more toweis.					

		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		315124	B. WING	B. WING		C 6/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REF			STREET ADDRESS, CITY, STATE, ZIP COI 439 BELLEVUE AVENUE TRENTON, NJ 08618	•	0/20/2024	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 584	Continued From pag	e 28	F 5	584			
	the facility, the surve which was occup which was occup and curtain pulled around to be with a pulled around the bottom of the cur. On 6/20/24 at 12:55 survey team and the presented with a phomogeneous privacy curtain were to be cleaned in needed and that it "s. Review of the facility wheelchairs, gerichal privacy curtain police 2024, included ensure kept clean and in goor review of all privacy of Soiling is noted. Renneed for cleaning seed. A review of the facility created February 20 has a right to a safe, Homelike Environment to receiving treatments afely A review of the facility Homelike Environment facility staff and man the extent possible, to	PM, in the presence of the when tograph of the observed a, stated that privacy curtains nonthly or more frequently if hould not look like that." Is "Cleaning and disinfecting irs, bedside commode, and y dated last reviewed March the that privacy curtains are od repair by: Conduct daily curtains to identify if any. hove and replace monthly/as					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING			C 06/26/2024	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 439 BELLEVUE AVENUE TRENTON, NJ 08618		30,20,202-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 584	Continued From paç	ge 29	F 58	34			
F 600 SS=G	NJAC 8:39-31.4(a) Free from Abuse and CFR(s): 483.12(a)(1	_	F 60	00		8/25/24	
	Exploitation The resident has the neglect, misappropriand exploitation as concludes but is not line corporal punishment any physical or cher treat the resident's missing \$483.12(a) The facil \$483.12(a)(1) Not us physical abuse, corpinvoluntary seclusion	ity must- se verbal, mental, sexual, or coral punishment, or n; T is not met as evidenced		Element 1: Corrective Action	ıs		
	documents, it was d failed to ensure a re NJ Exec Order 2 NJ Exec Order 26.4bd resident was NJ Exec sustained from an NJ E from an practice was identified	by staff was by staff to ensure the order 26.4b1 when they both and a sec Order 26.4b1. The deficient ed for 1 of 7 residents (Resident #254), and was lowing:		Resident #254 no longer resifacility. A review of the facility for resident #254 determined facility failed to ensure a resident MJ Exec Order 26.4b was VEXECORDER WAS WHENCORDER SHOPE WITH THE RESIDENT WITH THE RESIDENT WAS WHEN THE RESIDENT WAS WITH THE RESIDENT	documents that the dent who was by staff staff to ec Order 26.4b1 er 26.4b1 to from or of Nursing Certified		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING			06/3		
	ROVIDER OR SUPPLIER ARE NURSING AND REF			STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		06/2	26/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION S	SHOULD BE		(X5) COMPLETION DATE	
F 600	January 2024, include nursing is to provide an individual patient acute physical or me Physician/Nurse Prarabout the change in will be obtained for cuntil further evaluation plan will be initiated a centered intervention. On 6/17/24 at 1:00 P from the US FOIA On 6/17/24 at 1:00 P from the US FOIA (NJDOH) or any inverse or and or any inverse of the New Jet (NJDOH) or any inverse or and or any inverse or any inve	and procedure, dated revised led the aim of one-to-one continuous observation for for a period of time during intal illnessPrimary cititoner shall be notified patient's condition and order ontinuous 1:1 observation on. Resident/patient's care and/or updated with resident ins 2M, the surveyor requested (b)(6) 2 restigations for reportable ersey Department of Health estigations that included	F	expectation and process of cormulations when a resident has an have provided. On June 21, 2024, the Director initiated re-education the licensistaff and Certified Nursing Assi (CNAs) on continuous monitorious observation of a resident on or (1:1) monitoring for an individuation for a period of time during acut or mental illness. To notify the provider and responsible party, member of the change in the recondition and an order will be continuous 1:1 monitoring and observation until further evaluation of a continuous 1:1 log for compliant Element 2: Identification of at-If All residents have the potential affected by this practice. Element 3: Systemic Change On June 21, 2024, the Director Nursing/Designee in-serviced to licensed/certified nursing staff, Policy and Procedure for abusineglect. On July 25, 2024, the Director Nursing/Designee in-serviced to staff on the Policy and Procedure abuse and neglect. This will be by July 29, 2024.	r of Nursir sed nursir istants ing and ne-to-one la resident sed physician la resident sed physi	ng ng nt al or s for		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		315124	B. WING _			C 06/26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	IABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 439 BELLEVUE AVENUE TRENTON, NJ 08618	IP CODE	00/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE CROSS-REFERENCED DEFICE)		
F 600	resident's room and to bed with the saw the resident was made, and the saw the resident was made, and the saw the resident was made, and the saw the resident to saked the resident to saked the resident to saked the resident to saked the resident to the saw the resident to saked the resident to saked the resident to saked the resident to saked the resident to the saw the resident to saked the resident to	they were called to the hey observed the resident in vectored 26.4b1 on as Weecorder 26.4b1 on order 26.4b1. The resident was detailed to the seconder 26.4b1 on order 26.4b1 to the was detailed to the order 26.4b1 on order 26.4b1	F6	On July 25, 2024, the Dinitiated education to the all one-one (1:1) monitor morning meeting and wild High-Risk Meeting. DON/designee will revie monitoring logs in morning the high-risk meeting timely completion. Unit managers and superdaily random spot visual 2024, to assure that resemble 1:1 monitoring order have and in line sight of the result of the modern of	e US FOIA (b)(6) to bring to bring pring logs to eekly to the ew and audit all a ing meetings and weekly, to assure ervisors will initial audits on July a idents that have ve a 1:1 present esident. This will audit tool and high-risk meetin Quality Assurance ent Committee months. Based of its, a decision we need for continu	g 1:1 d re ate 25, I ng.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		315124	B. WING				26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		439	REET ADDRESS, CITY, STATE, ZIP CODE BELLEVUE AVENUE ENTON, NJ 08618	, , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 600	because the resident NJ Exec Order 20 Secondary and NJ Exec Order assessment no additive	ess Notes included a ated views order 26 at 3:06 PM, that d by the incoming staff an NJ Exec Order 26.4b1, it was 6.4b1 . Resident r 26.4b1 NJ Exec Order 26.4b1 and on onal views order 26.4b1 or s note indicated that the as discovered on the Incident at 8:30 AM. AM, the surveyor interviewed on a NJ Exec Order 26.4b1 so there in a NJ Exec Order 26.4b1 and exec Order 26.4b1 so there in a NJ Exec Order 26.4b1 The ff was looked at for possible stated that usually the exec (CNA) was with the laws "looked at." The user order 26.4b1 are in a NJ Exec Order 26.4b1 and exec (CNA) was with the laws "looked at." The user of speak to if the cameras	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315124	B. WING_			C 06/26/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 439 BELLEVUE AVENUE TRENTON, NJ 08618		00/20/2024	
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
F 600	A review of the Reside summary) reflected the facility with diagnous NJ Exec Order 26 May Exec Order 2	ent Face Sheet (admission ne resident was admitted to oses which included 6.4b1 erly Minimum Data Set nt tool dated 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		315124	B. WING		06/26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 600	confirm the physicial ordered NJ Exec Order 26 On 6/20/24 at 10:12 what the facilit was, and the spoken to, and any facility investigated origin, fractures of uverbal, physical, and stated they gathere hours prior to incide investigation was statements were gassessed, the state determined what on substantiated; and uput into place to pre occurring again. Reprovided by the facithat the NJ Exec Order 25% not immediately investigated investigation was statements were gassessed, the state determined what on substantiated; and uput into place to pre occurring again. Reprovided by the facithat the NJ Exec Order 25% not immediately investigation was stated.	There was no e medical record provided to an was made aware or AM, the surveyor asked the ty's process for investigating stated staff was interviewed the obtained, resident was additional witnesses. The skin tears, injuries of unknown anknown origin, complaints, d sexual abuse. The d statements from staff for 72 tent of unknown origin, and the arted immediately. After thered and the resident was ments were reviewed to accurred; if abuse was what interventions could be event the situation from eview of the investigation	F 600	DEFICIENCY)	
	also did not include NJ Exec Order 26.4b1 had resulted in Section 12.20 On 6/20/24 at 11:30	how the resident who was on an NJ Exec Order 26.4b1 that and NJ Exec Order 26.4b1. AM, the surveyor requested in for CNA #1's phone			
	On 6/20/24 at 12:17 CNA #2 and CNA # rooms. Both aides rooms were on	7 PM, the surveyor observed 3 outside of two resident confirmed the residents in the corder 26.451; and they both eone stayed with the resident			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING			1	C 26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	HABILITATION CENTER		439	EET ADDRESS, CITY, STATE, ZIP CODE BELLEVUE AVENUE ENTON, NJ 08618	1 00/	20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP			(X5) COMPLETION DATE
F 600	come to switch with the the resident NJ Exec On 6/20/24 at 1:24 Pthe US FOIA (b) (6) Them that they were NJ Exec Order 26.4b) also requested additional why the Progress Nothad a NJ Exec Order 26.4b) but it was not when the resident was NJ Exec Order 26.4b) that and NJ Exec Order 26.4b) acknowledged that the included how the resident who was resident was resident who was resident was resident who was resident	The survey team met with The survey team met with The surveyor informed still waiting for the resident's from NUESEC OTGET 26.451, and they conal information regarding stes documented the resident on their NUESEC OTGET 26.451 on their NUESEC OTGET 26.451 had an resulted in NUESEC OTGET 26	F	500			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER ARE NURSING AND REF	IABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 439 BELLEVUE AVENUE TRENTON, NJ 08618	DDE	1 00	20/2027	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE	
F 600	that they saw the rescontradicted the CNA #6 was with the 11:00 PM on Secondary and the Certified Nursing Assemble to the Certified Nursing Assemble that CNA #4 assignments that nig of William with Resident and they did not observe that they to statement from CNA NU Exec Order 26.451 took on hight as well. On 6/26/24 at 10:36 with the US FOIA concerns. The H6 no longer worked worked the Nursing H6 no longer worked worked h6 no longer wo	urse. CNA #6's statement ident at 8:00 AM for care that indicated resident from 7:00 AM until 1:00 PM to 7:00 AM sistant Assignment Schedule 1:00 PM to 7:00 AM shift, as well as an assignment #254. It is statement dated with a statement on 1:00 PM to 7:00 AM shift, arve any with solution of the are of Resident #254 that AM, the survey team met by (6) to discuss their confirmed CNA #1, #4, and at the facility, and CNA #5 and was currently not be should have been a continued that the incident that the	F	600				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315124	B. WING			C 06/26/2024	
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2024
BELLE CA	RE NURSING AND REH	ABILITATION CENTER			39 BELLEVUE AVENUE RENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607 SS=E	A review of the facility included each resident "abuse."residents was neglect, and harm whe facilityit is the policy "abuse" (mistreatment including injuries of use and misappropriation and thoroughly invest the process used to the happened NJAC 4.1(a)(5) Develop/Implement ACFR(s): 483.12(b)(1)- §483.12(b) The facility implement written policy and exploitate misappropriation of residual support investigate any succession support investigate any succession support in the s	how a resident or had staff should be with the staff should be protected from abuse, sile they are residing at the staff of this facility that reports of st., neglect, or abuse nknown source, exploitation of property) are promptly sigatedthe investigation is ry to determine what should be staff or s		600	DEFICIENCY		8/25/24
	QAPI program require §483.12(b)(5) Ensure	ed under §483.75.					

		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
		315124	B. WING		0.0	C 6/ 26/2024	
NAME OF PROVIDER OR SUPPLIER BELLE CARE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	06/26/2024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 607	Act. The policies and but are not limited to \$483.12(b)(5)(ii) Posemployee rights, as of (3) of the Act. §483.12(b)(5)(iii) Properties of the Act. §483.12(b)(5)(iii) Properties of the Act. This REQUIREMENT by: Based on interview, review of pertinent fare determined that the fatheir abuse policy to a background checks of employees before the complete license check their start date. The complete license checked by the following of the complete license their start date. The complete license checked by the following of the complete license their start date. The complete license checked by the following of the complete license the complet	the with section 1150B of the disprocedures must include the following elements. It ing a conspicuous notice of defined at section 1150B(d) Inhibiting and preventing distriction at section 1150B(d)(1) and distriction 1150B(d)(d)(d)(d)(d)(d)(d)(d)(d)(d)(d)(d)(d)(F		will files to fin timely o be stock (b) and ally ements e, and		
	checkEmployee So Before new employee residents, references employee will be veri	and criminal background reening and Training a. es are permitted to work with provided by the prospective fied as well as appropriate and certifications regarding		Administrator will audit all new e files specifically regarding crimin background, license, and refere check being completed in timely monthly for the next six months a findings to QAPI Committee.	al ence manner		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	315124	B. WING			C 06/26/2024	
NAME OF PROVIDER OR SUPPLIER BELLE CARE NURSING AND RE	EHABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CO 439 BELLEVUE AVENUE TRENTON, NJ 08618			
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
Criminal backgroun all prospective emp facility's policy in cri On 6/20/24 at 12:47 from the US FOIA ten employes standard survey what terminated from the their personnel and A review of employer following: For Employee #9, a date of Total Control of the check prior of the license check, refer background check pemployment. On 6/25/24 at 12:57 the US FOIA (b) facility's screening personnel of the check pemployment to ensure the check prior of the check pemployment to ensure the check pemployment the check pem	ployee's backgroundd. d check will be conducted on loyees as provided by the iminal background check 7 PM, the surveyor requested (b)(6) ee files hired since last to were currently employed or e facility. The files include both medical. ee personnel files revealed the a US FOIA (b)(6) with a start the was no evidence of a for to the start of employment. an US FOIA (b)(6) with a start there was no evidence of a fence check, or criminal prior to the start of	F	Element 4 The results of the weekly ar will be submitted to the Qua and Process Improvement Meeting monthly for 6 mont the results of these audits, be made regarding the nee submission and reporting.	ality Assurance Committee ths. Based on a decision will		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315124	B. WING		C 06/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REF	IABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	1 00/20/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHI) TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		BE COMPLETION	
F 607	employee should have reference check prior	the missing pre-employment who confirmed every we a criminal background and r to employment.	F 60	7		
F 610 SS=D	CFR(s): 483.12(c)(2) §483.12(c) In responneglect, exploitation, must: §483.12(c)(2) Have exploitations are thorough substitutions in proceedings of the substitution in the substitution substi	Sorrect Alleged Violation -(4) se to allegations of abuse, or mistreatment, the facility evidence that all alleged ghly investigated. In further potential abuse, or mistreatment while the agress. In the results of all administrator or his or her tative and to other officials in the law, including to the State in 5 working days of the leged violation is verified e action must be taken. In is not met as evidenced	F 61		8/25/24	
	documents, it was defailed to a.) initiate ar an NJ Exec Order 2	nd review of pertinent facility etermined that the facility n investigation at the time of 6.4b1 was discovered on		Element 1: Corrective Actions Resident #254 no longer resides at the facility. A review of the facility docum for resident #254 determined that the facility failed to initiate an investigation investigation at the time of identifying resident with an NJ Exec Order 26.4 and complete a thorough investigation.	ents e on an g a lb1	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
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		315124	B. WING		06	6/26/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				439 BELLEVUE AVENUE		
BELLE CA	ARE NURSING AND REI	HABILITATION CENTER		TRENTON, NJ 08618		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	-CTION	(X5)
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	1			,		
F 610	Continued From pag	ne 41	F 610			
		staff had an ^{NJ Exec Order 26.4b1} .		how a resident on NJ Exec Order 26.4	lb1	
		e was identified for 1 of 7		NJ Exec Order 26.4b1 sustained NJ Exec Order	der 26.4b1	
		or Nexecorde (Resident #254),				
	and was evidenced I			On July 25, 2024, the Director of	Ī	
				Nursing/Designee initiated re-ed	ucation to	
	A review of the facilit	-		the licensed nursing staff on inci		
		and procedure dated revised		accident policy and procedure for		
	1	ded the aim of one-to-one		investigating an alleged incident		
		continuous observation for		residents with an injury of unkno		
		for a period of time during		On July 25, 2024, the Director of		
		ental illnessPrimary		Nursing/Designee will initiate an		
	1 -	ctitioner shall be notified patient's condition and order		the 24-hour report to identify any occurrences of injuries of unknown	•	
		continuous 1:1 observation		to assure that an incident report	•	
		on. Resident/patient's care		investigation has been initiated.	unu	
		and/or updated with resident		Element 2: Identification of at-Ri	sk Areas	
	centered intervention	•		All residents have the potential to	o be	
				affected by this practice.		
				Element 3: Systemic Change		
		PM, the surveyor requested		All Incident reports will be brough		
	from the US FOIA			daily morning meeting by the un		
		vestigations for reportable		manager and/or designee for rev	•	
		ersey Department of Health		the interdisciplinary team (IDT) to		
		estigations that included NJ Exec Ord NJ Exec Order 26.4b1 and		a thorough investigation and cor of the incident report.	npietion	
		NJ Exec Order 26.4b1		On July 25, 2024, the Director of	f	
	loi alid			Nursing/Designee will initiate re-		
	The surveyor review	ed an investigation for the		to the unit managers to bring all		
		rd for Resident #254.		reports to morning meeting and		
				the High-Risk Meeting.	-	
		ent Report dated 8/14/23 at		A weekly random audit will be in		
		nat the US FOIA (b)(6)		the DON/designee of 5 incident	•	
		s called to Resident #254's		completed to ensure that the inc		
	room to assess the r	resident who had		reports are completed with a tho		
	N.I. Evo a Ordon O	aNJ Exec Order 26.4b1 by		investigation and root cause iden		
	NJ Exec Order 2			and/or conclusion as why the inc		
	; NJ Exec Or When staff atte			occurred, and the interventions place to assure the incident will		
	they NJ Exec Ord			place to assure the incident will a continue to occur.	iot	
	uicy	, uic was		Johnson Colour.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF B	DOLUBER OF OURDLUES	315124	D. WING _	0.775.77.177.777.777.777.777.777.777.777.		06/26/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
BELLE CA	ARE NURSING AND F	REHABILITATION CENTER		439 BELLEVUE AVENUE			
				TRENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 610	made aware and to send to the NJ The report indicate comments or step included resident every shift on dated were and they observed and NJ Exec Order and NJ	a new order was put into place Ex Order 26.4b1 ed no witnesses with additional is taken to prevent recurrence will be NJ Exec Order 26.4b1 A review of the statement the US FOIA (b)(6) e called to the resident's room of the resident in bed with order 26.4b1 In The many Exec Order 26.4b1 with and NJ Exec Order 26.4b1 The many Exec	F	On July 25, 2024, the Direct Nursing/Designee re-educa licensed nursing staff to initi investigation at the time of it resident with an injury of un and complete a thorough inhow a resident on one-to-or monitoring sustained an injuto an unwitnessed fall. Element 4: Monitoring/ Quanthe results of the weekly ar will be submitted to the Quanthe and Process Improvement (Meeting monthly for 6 monther results of these audits, abe made regarding the needs submission and reporting.	tor of ted the ate an dentifying a known origin vestigation of ne (1:1) ury secondary lity Assurance nd daily audits ality Assurance Committee ths. Based on a decision will		
	shift. A review of an add	ditional Incident Report included n packet dated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315124	B. WING		C 06/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REI	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	1 00/20/2024	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 610	PM, prepared by the saw the resident on asked the resident stated the resident stated the resident stated that the resident had because the resident properties and NJ Exec Order 26.4b properties and NJ Exec Order 26.4b properties and not on Report dated properties and not on Report dated properties and not have been should not have been sho	included that they and the sident about their and the resident about their and the resident about their and the resident did not ress Notes included a at 3:06 PM, that a side by the incoming staff an NJ Exec Order 26.4b1, it was a NJ Exec Order 26.4b1, it was 6.4b1. Resident and on ec Order 26.4b1 noted except with NJ Exec Order 26.4b1 or is note indicated that the was discovered on the Incident at 8:30 AM. AM, the surveyor interviewed 6.5	F 61			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315124	B. WING				C 06/26/2024	
	ROVIDER OR SUPPLIER			439 B	ET ADDRESS, CITY, STATE, ZIP CODE BELLEVUE AVENUE NTON, NJ 08618		00/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 610	Continued From page	e 44	F 6	310				
	The surveyor continu medical record for Re	ed to review the closed esident #254.						
	(MDS), an assessme reflected the resident NJ Exec Order 26 but is able if NJ Exec Order 26.4 to NJ Exec Order NJ Exec Order 26.4 to Surfaces including to wheelchair, standing	NJ Exec Order 26.4b1 with 6.4b1 or NJ Exec Order 26.4b 1 or NJ Exec Order 26.4b 1 and b1 by NJ Exec Order 26.4b1 Order 26.4b1. The MDS esident NJ Exec Order 26.4b1 between						
	Resident #254 was p NJ Exec Order 26.4b1 because NJ Exec Order 29 The STOIA (DIRECTION OF STOIA (DIRECTION OF STOIA (DIRECTION OF STOIA (DIRECTION OF STATE OF STOIA (DIRECTION OF STATE OF STOIA (DIRECTION OF STATE OF ST	who stated she thought laced on a NJ Exec Order 26.461 in they were NJ Exec Order 26.461 and a stated thought were still lacking						
	was, and the statements were	AM, the surveyor asked the 's process for investigating ated staff was interviewed obtained, resident was ditional witnesses. The						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		315124	B. WING		í	C 06/26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 610	stated they gathered hours prior to NJ Eximinvestigation was statements were gat assessed, the stater determined what occurring again. On 6/20/24 at 11:30 from the state occurring again. On 6/20/24 at 12:17 CNA #2 and CNA #3 rooms. Both aides or rooms were on succonfirmed that some confirmed that some come to switch with the resident was Succonfirmed that they were surveyor also requeregarding why the P the resident's had a on Succonfirmation on how a had an Succession was stated to the survey information on how a had an Succession was stated to the stated that they were surveyor also requeregarding why the P the resident's had a succession on how a had an Succession was stated to the stated that they were surveyor also requeregarding why the P the resident's had a succession on how a had an Succession was stated to the stated that they were surveyor also requeregarding why the P the resident's had a succession on how a had an Succession was stated to the stated that they were surveyor also requeregarding why the P the resident's had a succession was stated to the stated that they were surveyor also requeregarding why the P the resident's had a succession was stated to the stated that they were surveyor also requered to the succession was successive to the stated that they were surveyor also requered to the succession was successive to the succession was success	The statements from staff for 72 (sec Order 26.4b1), and the carted immediately. After thered and the resident was ments were reviewed to curred; if was what interventions could be went the situation from AM, the surveyor requested in for CNA #1's phone PM, the surveyor observed 3 outside of two resident confirmed the residents in the confirmed the residents in the cone stayed with the resident try hour another aide would them. They both confirmed size order 26.4b1.	F	610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING			C 06/26/2024		
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 439 BELLEVUE AVENUE TRENTON, NJ 08618)DE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE	
F 610	On 6/26/24 at 9:45 at 19:45 and Name of through 11:00 PM; (from Name of through 11:00 PM of the that they saw the recontradicted that they saw that the that they saw the recontradicted that they saw the recontradicted that they saw that the that they saw the recontradicted that CNA assignments that night of the they did not observed did not the they that they did not observed did not the they that they did not observed did not the they that they they did not observed did not the they that they are of the they have of the they are of the the	AM, the surveyor reviewed the for Resident #254 for resident that CNA #1 was lent on a condition of the form of th	F6	510				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(×	(X3) DATE SURVEY COMPLETED C 06/26/2024	
		315124	B. WING				
	ROVIDER OR SUPPLIER ARE NURSING AND F	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP O 439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE	33.23.232	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 610	should have included resident, interview resident interview of the facility definition included each resident included each resident included each resident included each resident interview of the facilityresident included each resident included each	to discuss their stated an investigation ded an assessment of the sof possible witnesses and if needed, sure eventions put in place so will and ICCP was updated. The defect of the summary, erventions put in place so will and ICCP was updated. The defect of the summary, erventions put in place so will and ICCP was updated. The defect of the summary of the facility, and CNA #5 worked and was currently not in the should have been a statement. The state of the incident either of the sesses of the resident's on acknowledged the CNA of bed or stated the resident was unable to state of the state of t	F	510			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 610	and misappropriation and thoroughly inves the process used to thappened NJAC 8:39-4.1(a)5	inknown source, exploitation of property) are promptly tigatedthe investigation is try to determine what	F 610			
F 641 SS=E	§483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on observation review, it was determ accurately assess a maccurately a	of Assessments. It accurately reflect the It is not met as evidenced In, interview, and record Inined that the facility failed to In resident's status in the In Important the service of the servi	F 64	F641 Accuracy of Assessments Element 1: Corrective Actions Resident # 29 had an updated MDS completed on ASSEST Level . Resident #60 had an updated MDS completed on To accurately reflect their ASSEST Level . Resident # 73 had an updated MDS completed on To Execurate to accurately reflect their ASSEST Level . Resident # 73 had an updated MDS completed on To Execurate their ASSEST Level . Resident # 80 had an updated MDS completed on To Execurate their ASSEST Level . Resident # 80 had an updated MDS completed on To Execurate their ASSEST Level . Resident # 96 had an updated MDS completed on To Execurate their ASSEST Level . Resident # 96 had an updated MDS completed on To Execurate their ASSEST Level . The Director of Nursing/designee will provide re-education to the Policy and Procedure for Completion of MDS and Resident Assessment Instrument (RAI) Process.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		DATE	
F 641	(admission summary was admitted to the fincluded but were now the composet (MDS), an assess reflected a brief inter (BIMS) score of coursident had a NJE addition, in Section indicated that the resident Review (PANJ Exec Order 26.4b) or a related condition. A review of a level resident Review of a level resident Review (PANJ Exec Order 26.4b) or a related condition. A review of a level resident had and that a PANJ in addition, a review and that a PANJ in addition, a review resident had some similar to complete a month of the MDS for Resident had to complete a month of the facility had change that there were inaccounted that there were inaccounted to the MDS FOIA (b) (6) and US FOIA (b) (6) and US FOIA (b) (6) and US FOIA (b) (6) (6) and US FOIA (b) (6) (6) (6) (6) (6) (6) (6) (6) (6) (6	reflected that the resident acility with diagnoses that the limited to with the resident acility with diagnoses that the reflected that the resident acility with diagnoses that the reflected to with the reflected to the reflect	F 6	Element 2: Identification All residents have the paffected by this practice Element 3: Systemic Clark The Director of Nursing provide re-education to Policy and Procedure for MDS and Resident Assanstrument (RAI) Proce The Director of Nursing conduct a weekly time amonthly time 3 months MDS and Resident Assanstrument (RAI) to enswith the residents statu Element 4: Monitoring/ The results of the audit to the Quality Assurance Improvement Committee for 4 months. Based on these audits, a decision regarding the need for submission and reporting	cotential to be e. change g/designee will o the US FOIA (b)(6) on the for Completion of sessment ess. g/designee will 4 weeks and audit of 5 resid sessment sure it is consiste is. Quality Assurant is will be submitt be and Process ee Meeting mont in the results of m will be made continued	ent ent ent nce red	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		315124	B. WING				26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REA	HABILITATION CENTER	•	439	REET ADDRESS, CITY, STATE, ZIP CODE B BELLEVUE AVENUE RENTON, NJ 08618	, 00.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	with the US FOIA that the previous US approximately US FOIA (b) (6) state been working to uploate computer system an current computer system an current computer system and current system and current system and current system and current computer system and current system and current system and current computer system and current syste	PM, the survey team met (b)(6) stated FOIA (b)(6) resigned Order 26.4b1, and the current arted in Subsection of the previous d paper versions to the stem. 27 AM, the surveyor 60 in their room watching #60 stated that they were to SUBSECTION OF THE STATE OF THE STA	F	641			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315124	B. WING			C 6/26/2024	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (439 BELLEVUE AVENUE TRENTON, NJ 08618		0/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 641	On 6/20/24 at 12: interviewed the Use who identified that where attempting to "clear The Use FOIA (b) were aware of Reconfirmed that the On 6/25/24 at 1:30 of the Use FOIA acknowledged that coded incorrectly. 3. On 6/19/24 at 1 observed Resider #73 explained that The surveyor reviewed Resident #73: A review of the Orthat Resident #73 diagnosis that incomplete the out of 15, whice out of 15, whice	DS assessment failed to #60 as a current NExec Order 26.451. 11 PM, the survey team S FOIA (b)(6) via telephone, the MDS department was a they arrived and has been an it up" since arriving in NEXEC ORDER 26.451, and e MDS was coded incorrectly. 10 PM, the NEXEC ORDER 26.451, and e MDS was coded incorrectly. 11 PM, the survey department was an they arrived and has been an it up" since arriving in NEXEC ORDER 26.451, and e MDS was coded incorrectly. 12 PM, the NEXEC ORDER 26.451, and e MDS was coded incorrectly. 13 PM, the Surveyor in the presence (b)(6) 14 PM, the Surveyor in the presence (b)(6) 15 PM, the NEXEC ORDER 26.451 16 PM, the Surveyor in the presence (b)(6) 16 PM, the Surveyor in the presence (b)(6) 17 PM, the Surveyor in the presence (b)(6) 18 PM Surveyor in the presence (b)(6) 19 PM, the Surveyor in the presence (b)(6) 10 PM, the Surveyor in the presence (b)(6) 10 PM, the Surveyor in the presence (b)(6) 10 PM, the Surveyor in the presence (b)(6) 11 PM, the survey team they are coded in the presence of the presen	F	641			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	(X	3) DATE SURVEY COMPLETED
		315124	B. WING			C 06/26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE 439 BELLEVUE AVENUE TRENTON, NJ 08618	TE, ZIP CODE	00/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 641	plan (ICCP) included NJ Exec Order 2 included: I will have another focus area, NJ Exec Order 2 On 6/19/24 at 10:20 Certified Nursing As both confirmed that and was due to the On 6/20/24 at 11:23 Unit Manager/Licens #1) who identified R On 6/20/24 at 7:50 A the US FOIA (b)(6) they are aware of Re that the MDS should The RAI manual, ve Page H-8 provided to coding this question for bladder or incont sheets, nursing asse physician history, ar Interview the resider reliably reporting the family members or s resident is not able to Ask direct care staff	idualized comprehensive care d a focus area dated es of daily living (ADL) 26.4b1 Interventions all my needs met. In addition, dated [N] sevidenced by: 26.4b1 as evidenced by: 26.4b1 . AM, the surveyor interviewed sistant (CNA #1 and #2), who Resident #73 [N] Exec Order 26.4b1 being [N] Exec Order 26.4b1	F	641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		COMPLETED		
		315124	B. WING			06/26/2024		
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	'			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 641	Continued From pa	ge 53	F 64	41				
	4. The surveyor rev record for Resident	iewed the closed medical #96.						
	indicated that the re	nission Record face sheet esident was admitted to the is that included but not limited ler 26.4b1						
	A review the comprisindicated in Section							
	use while a residen	was coded as in t.						
	A review of the med indication that Resid	lical record included no dent #96 was on a						
	the US FOIA (b)(6 Resident #96 was r	who confirmed that of on a Newsconding while in the assessment was not coded						
	the US FOIA (b)(6)	AM, the survey team met with who both acknowledged that ent #96 was inaccurate.						
	Page O-5 provided coding this question or pneumatically po mechanical ventilation adequate ventilation may become (such unable to support them. During invasive	ersion 1.18.11, October 2023, the following guidance for a Code any type of electrically wered closed-system or support device that ensures a in the resident who is or who as during weaning attempts) heir own respiration in this te mechanical ventilation the tis controlled by the ventilator.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING			1	C / 26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH			STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		1 00	720/2024
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	2 54	F	641			
	5. On 6/17/24 at 10:5 observed Resident #8 NJ Exec Order 26	30 lying in bed NJExec Order 28-4)) via					
	The surveyor reviewe Resident ##80.	ed the medical record for					
	reflected the resident	esion Record face sheet was admitted to facility with uded NJ Exec Order 26.4b1					
	of 15; indicating a of Section included	had a BIMS score of out Exec Order 26.4b1. A review the resident had an out Exec Order 26.4b1 and Section of Order 26.4b1.					
		COrder 26.4b1 if NJ Exec Order 2					
	the US FOIA (b)(6)	PM, the surveyor interviewed via the phone who ection for the MDS for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		315124	B. WING			C 06/26/2024
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		1012012024
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 641	been coded for added computer systems inaccuracies in the US FOIA (b)(6) the MDS for Residual A review of facility MDS" reviewed 04 MDS Coordinator is completion of the Indicated that "Sec Nursing/Therapy Day Instrument (RAI) Papril 2023, include Manager will oversident as part of Instrument (RAI) p for the State-speci Data Set (MDS) will added to the State-speci Data Set (MDS)	that the facility had changed and that there were transfer. AM, the survey team met with who both acknowledged that ent #80 was inaccurate. provided policy "Completion of 2023 indicated that: "The RN s responsible for ensuring the MDS." This policy also stion O is to be completed by	F 64	1.1		
F 656 SS=D	CFR(s): 483.21(b) §483.21(b) Compr §483.21(b)(1) The implement a comp	t Comprehensive Care Plan	F 65	56		8/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING			C 06/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND RE	EHABILITATION CENTER	•	439	REET ADDRESS, CITY, STATE, ZIP CODE D BELLEVUE AVENUE ENTON, NJ 08618	1 00.	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	objectives and time medical, nursing, a needs that are identical assessment. The condescribe the following in the services that or maintain the resiphysical, mental, at required under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclustreatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resident's represent (A) The resident's redistred outcomes. (B) The resident's put the discharge. For whether the resident community was associal contact agence entities, for this pur (C) Discharge plant plan, as appropriate requirements set for section. §483.21(b)(3) The	includes measurable frames to meet a resident's and mental and psychosocial tified in the comprehensive comprehensive care plan must ang - t are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 43.25 or §483.40 but are not aresident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative(s)- joals for admission and preference and potential for acilities must document active desire to return to the sessed and any referrals to ies and/or other appropriate	F	656			

CENTER	3 FOR MEDICARE &	MEDICAID SERVICES				OIVID IVO	<u>. 0930-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		315124	B. WING _			06/	26/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DELLE CA	ADE NUDCINO AND DEU	A DIL ITATION CENTED		43	39 BELLEVUE AVENUE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER		Т	RENTON, NJ 08618		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	115	
F 656	Continued From page	e 57	F	656			
	(iii) Be culturally-com	petent and trauma-informed.					
		Γ is not met as evidenced					
	by:						
		n, interview, and review of			F656-Develop/Implement		
	pertinent facility docu	ments, it was determined			Comprehensive Care Plan		
	that the facility failed	to develop and implement			Element 1: Corrective Actions		
	an individualized com	nprehensive care plan			Resident #73□s care plan was update	d to	
	(ICCP) consistent wit	h the resident's history of			include goals and interventions related	to	
	NJ Exec Order 26.4b1 . This de				the resident⊡sNJ Exec Order 26.4b1 .		
		esidents reviewed for care			On July 25, 2024, the Director of		
		73), and was evidenced by			Nursing/Designee will initiate re-educa	tion	
	the following:				to the interdisciplinary team that all		
					residents admitted to the facility must		
	On 6/10/24 at 10:01	AM the currence channed			have a individualized comprehensive or plan (ICCP) for all residents with a hist		
	Resident #73 in their	AM, the surveyor observed			of N Exec Order 26.4b1	Ol y	
	rtesident #75 in their	TOOM.			On July 25, 2024, the Director of		
	On 6/20/24 at 11:23 /	AM, the surveyor interviewed			Nursing/Designee will initiate an audit	of	
		who stated an ICCP			current residents, to ensure that all		
		resident" and explained what			residents that have a NJ Exec Order 26.4b1		
	needed to be done or	r expected for the resident.			has a care plan that includes		
		at a resident's NJ Exec Order 26.4 or			goals and interventions.		
		^{26.4b1} should be identified on			Element 2: Identification of at-Risk Are	as	
	the ICCP.				All residents have the potential to be		
					affected by this practice.		
		M, the surveyor interviewed			Element 3: Systemic Change		
	the US FOIA (b)(6) regarding Resident			On July 25, 2024, the Director of	OM	
	NULE CONTROL AND ALL	identified Resident			Nursing/Designee will in-service the		
	#73 as a N Ex Order 25.451				on the Policy and Precedure f	or	
	The curveyer reviewe	ed the medical record for			on the Policy and Procedure for developing an individualized	וכ	
	Resident #73.	od tile illedical record IOI			comprehensive care plan with a focus	for	
	r condent π10.				residents admitted to the facility with a		
	A review of the Order	Summary Report revealed			history of NJ Exec Order 26.4b1.		
		is admitted to the facility with			On July 25, 2024, the Director of		
	diagnosis that include	•			Nursing/Designee will initiate re-educa	tion	
	NJ Exec Order 26				to the unit managers to bring all new		
					admissions paperwork to morning		
					meeting.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		315124	B. WING _			C 06/26/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	00/20/2024
				439 BELLEVUE AVENUE		
BELLE CA	ARE NURSING AND RE	HABILITATION CENTER		TRENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIAT	
F 656	Continued From pag	ge 58	F 6	556		
		clude a focus area identifying		On July 25, 2024, the Di	rector of	
		y as being a NJ Exec Order 26.4b1.		Nursing/Designee will ini		on
				to the Unit Managers and		
		PM, the in the presence		that o	care plans for	
	of the US FOIA (b	0)(6)		residents with a history of		
	an	nd survey team acknowledged		upon admission need to morning meeting for revi		
		ICCP should have identified		interdisciplinary team.	ew by the	
		NJ Exec Order 26.4b1		The Director of Nursing/I	Designee will	
		<u> </u>		complete monthly audits		
		ty's undated "Care Plan"		residents with a history of		
		all residents admitted to the quate person centered care		that they have a Care Plant Element 4: Monitoring/ C		<u>,</u>
		or all their needs in a timely		The results of the month		·
		[] 2. They will include initial		submitted to the Quality		
		orders] orders, medications,		Process Improvement C		ng
	_	orders, therapy orders, social		monthly for 3 months. B		
		RR recommendations11.		results of these audits, a		•
	revisions will be ma	pdated timely and necessary		made regarding the need submission and reporting		
		uo		Submission and reporting	j.	
E 057	NJAC 8:39-31.2(e)	ad Davisian		.57		0/05/04
F 657 SS=D			F 6	157		8/25/24
	§483.21(b) Comprel	hensive Care Plans				
		nprehensive care plan must				
		7 days after completion of				
	the comprehensive					
		nterdisciplinary team, that				
	includes but is not li					
	(A) The attending ph					
	(B) A registered nurs	se with responsibility for the				
		h responsibility for the				
		od and nutrition services staff.				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		315124	B. WING				26/2024
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DELLE CA	ARE NURSING AND REH	JARII ITATION CENTER		4:	39 BELLEVUE AVENUE		
BELLE CA	THE NORSING AND REP	ABILITATION CENTER		Т	RENTON, NJ 08618		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
IAG			IAG		DEFICIENCY)		
F 657	Continued From page	e 59	F	657			
	(E) To the extent prac	cticable, the participation of					
	the resident and the	resident's representative(s).					
	An explanation must	be included in a resident's					
		participation of the resident					
		oresentative is determined					
	not practicable for the	e development of the					
	resident's care plan.						
		e staff or professionals in					
		nined by the resident's needs					
	or as requested by th						
		vised by the interdisciplinary					
		essment, including both the					
	comprehensive and cassessments.	quarterly review					
		T is not met as evidenced					
	by:	is not met as evidenced					
	_ ·	on, interview, and review of			F657 □ Care Plan Timing and Revision	,	
		uments, it was determined					
		to revise an individualized			Element 1: Corrective Actions		
		plan (ICCP) in a timely			On July 25, 2024, the Director of		
	manner for a residen	· · · · · · · · · · · · · · · · · · ·			Nursing/Designee will initiate re-educat	ion	
	discontinued. This d				to the Unit Managers and US FOIA (b)(6)		
	identified for 1 of 35 i	residents reviewed for			that when an order i	is	
	comprehensive care	plans (Resident #60), and			discontinued the care plan must be		
	was evidenced by the	e following:			updated.		
					On July 29, 2024, the Director of		
					Nursing/Designee will initiate an audit to	o	
		AM, the surveyor observed			assure that care plans are updated to		
		room watching television.			reflect the discontinuation or		
	The resident was not				orders/interventions that have associate	∌d	
	NJ Exec Order 20	0.401			care plans written.		
	The our reviews	ad the medical reserve for			The Director of Nursing/ Designee		
	Resident #60.	ed the medical record for			updated the care plan of Resident # 60 to reflect current status.	⊔ຮ	
	Nesident #00.				Element 2: Identification of at-Risk Area	30	
	Δ review of the Admis	ssion Record face sheet (an			All residents have the potential to be	io .	
		reflected the resident was			affected by this practice.		
	admitted to the facilit				Element 3: Systemic Change		
	included, but not limit	ted to NJ Exec Order 26.4b1			On July 25, 2024, the Director of		
	,, Nat 110t 1111111		1		1 2 25, 20, 202 ., 410 21100001 01	,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		315124	B. WING	B. WING		C 06/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		43	TREET ADDRESS, CITY, STATE, ZIP CODE 39 BELLEVUE AVENUE RENTON, NJ 08618	001	20/2024
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
F 657	Data Set (MDS), an a status (BIMS) score of indicated a NJ Exec order of the ICCP of the I	recent quarterly Minimum assessment tool dated rief interview for mental of out of 15, which order 26.4b1. included a focus area dated of daily living (ADL) 6.4b1 Interventions Exec Order 26.4b1 a 1. Further review of the object of the order 26.4b1 at 1. Further review of the order 26.4b1 at 2. Summary Report reflected to order 26.4b1 at 3. Summary Report reflected to order 26.4b1 at 4. Summary Report reflected to order 26.4b1 at 3. Further review of the order 26.4b1 at 4. Summary Report reflected to order 26.4b1 at 4	F	657	Nursing/Designee will initiate re-educate to the Unit Managers, US FOIA (b)(6) and interdisciplinary team members on the Policy and Procedure reviewing and updating as needed a resident scare plan. A weekly audit of 5 -care plans will be audited by the DON and/or designee to assure that care plans are updated to reflect the discontinuation or orders/interventions that have associate care plans written. Element 4: Monitoring/ Quality Assurant The results of the weekly will be submit to the Quality Assurance and Process Improvement Committee Meeting mont for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	for ed nce tted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		315124	B. WING		C 06/26/2024		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	00/	20/2024	
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 657	and was adjust to use it On 6/26/24 at 10:35. the US FOIA (b)(6) acknowledged that the but was still identified. A review of the facility policy included all reswill have adequate put that provide for all the mannerProcedure goals, MD orders, medietary orders, therapy and PASARR recommission will be updated timely will be made NJAC 8:39-27.1(a)	AM, the US FOIA (b)(6) and survey team ne order was discontinued d on the ICCP. y's undated "Care Plan" sidents admitted to the facility erson centered care plans eir needs in a timely [] 2. They will include initial edications, treatments, by orders, social services, mendations11. Care plans y and necessary revisions	F 65				
	CFR(s): 483.21(b)(3) §483.21(b)(3) Composition The services provide as outlined by the comust- (i) Meet professional This REQUIREMENT by: Based on observation	rehensive Care Plans d or arranged by the facility, mprehensive care plan, standards of quality. I is not met as evidenced ons, interview, and review of	F 65	F658 □ Services Provided meet		8/25/24	
		ments, it was determined to a.) administer multiple		Professional Standards Element 1: Corrective Actions			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		315124	315124 B. WING _				C /26/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2024	
					39 BELLEVUE AVENUE			
BELLE CA	RE NURSING AND RE	HABILITATION CENTER			RENTON, NJ 08618			
(V4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 658	Continued From pag	ge 62	F	658				
		tiple dates and times on a			Upon identification, on 6/19/24, a revie	\ \ /		
		ec Order 26.4b1, and b.) ensure			of the medication regimen was conduc			
		ician's order was removed			for the following residents:	.ou		
	from active orders in				Resident #32 with nursing staff to ensu	ıre		
		rds of practices. This deficient			that the resident received their medica			
	practice was identifi	ed for 4 of 4 residents			on timely basis. Any discontinued orde	rs		
	reviewed for medica	ition administration times			have also been removed from active			
		#60, and #250) and 1 of 24			orders.For resident #32 a medication e	rror		
residents reviewed for professional standards of				report was completed.				
	practice (Resident#	60).			Resident #43 with nursing staff to ensu			
					that the resident received their medica			
	D ()	0			on a timely basis. Any discontinued ord	iers		
		sey Statutes Annotated, Title			have also been removed from active orders.For resident #43 a medication e			
		sing Board. The Nurse State of New Jersey states:			report was completed.	HOI		
	"The practice of nur				Resident #60 with nursing staff to ensu	ırΔ		
		s defined as diagnosing and			that the resident received their medica			
	Te	onses to actual and potential			on a timely bases. Any discontinued			
		nal health problems, through			orders have also been removed from			
		se finding, health teaching,			active orders.For resident #60 a			
	health counseling, a	nd provision of care			medication error report was completed			
	supportive to or rest	orative of life and wellbeing,			Resident # 60 had a NJ Exec Order 26.40 order in	i		
	_	cal regimens as prescribed by			place for the Nursing discharged	the		
		rise legally authorized			order in the TAR for consistency.			
	physician or dentist.	"			Resident #250 with nursing staff to ens			
	Defense as New Jee	Ot-total American Title			that the resident received their medica			
		sey Statutes Annotated, Title			on a timely basis. Any discontinued order have also been removed from active	iers		
		sing Board. The Nurse State of New Jersey states:			orders.For resident #250 a medication			
		sing as a licensed practical			error report was completed.			
		performing tasks and			Pharmacy Consultant to complete			
		n the framework of case			monthly medication passes on four nu	ses		
	· · · · · · · · · · · · · · · · · · ·	he patient and family teaching			for 3 months.			
		alth teaching, health			On July 25, the Director of			
		rision of supportive and			Nursing/Designee will initiate a weekly			
	restorative care, und	der the direction of a			audit by 4 weeks and monthly by 3			
	registered nurse or licensed or otherwise legally				months of all physician orders to assur	е		
	authorized physiciar	n or dentist."			that all discontinued orders are no long	•		
			1		listed on the medication administration			

OL. VILLI	C . C	INLEDIO/ (ID CEITVICE)					0000 0001	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		(c	
		315124	B. WING			06/	26/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BELLE CA	ARE NURSING AND REH	IABILITATION CENTER			39 BELLEVUE AVENUE			
				Т	RENTON, NJ 08618			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658	Continued From page	o 63		658				
1 000				000				
	The deficient practice			record and discontinue any orders per				
	following:				physician orders.	.,		
					On July 27, 2024, an audit was done by the DON/Designee of all medication	у		
	1 During entrance of	onference on 6/17/24 at			orders to assess opportunities to			
		or asked the US FOIA (b)(6)			streamline the medication pass so that	iŧ		
	10:00 7 tivi, trie sarvey	voi disked the			is completed timely and as per physicia			
	hov	w the facility's staff was, and			orders.	***		
	the US FOIA (b)(f) stated that	the facility relied heavily on			On July 27, 2024, an audit was done b	V		
		hat time, the surveyor			the DON/Designee of discontinued	.,		
	requested the Nurse				medication orders to assure they are			
	completed for the we	eks of 11/6/22 to 11/19/22.			removed from the active orders			
					For resident #32 a medication error rep	ort		
	On 6/18/24 at 11:56	AM, the user (a) informed the			was completed.			
	surveyor that the faci	lity did not have the staffing			For resident #43 a medication error rep	ort		
		t they were trying to get the			was completed.			
		payroll company. The			For resident #60 a medication error rep	ort		
		if the facility needed to			was completed.			
	maintain staffing reco				For resident #250 resident no longer	der 26.		
	confirmed the facility	should have the records.			resides in the facility. Discharged			
	On 6/25/24 at 10:13	AM, the surveyor reviewed						
	the Nurse Staffing Re	eport sheets completed by						
	the facility for 11/6/22	2 through 11/19/22 which			Pharmacy Consultant to complete			
	revealed the facility h	ad zero to four nurses			monthly medication passes on two			
	scheduled daily in a t	wenty-four hour period.			nurses.			
	At that time, the	stated that the facility						
	could not locate the N	November 2022 staffing			Element 2: Identification of at-Risk Area	as		
		d payroll documents to			All residents have the potential to be			
	complete the staffing				affected by this practice.			
	-	vily on Agency staff who			Element 3: Systemic Change			
	were not included in	those reports.			On June 21, 2024, the Director of Nurs			
					in-serviced the licensed nursing staff or			
		AM, the surveyor interviewed			the Policy and Procedure for medicatio			
		in the presence of the e was not here at the time,			administration and administration times	;		
				and that orders are discontinued per				
	and could not locate			physician orders.				
	time. The US FOIA	(b)(6) stated she could			A weekly audit for 4 weeks and monthly	y		

PRINTED: 11/08/2024 FORM APPROVED OMB NO. 0938-0391

OLIVILIV	STOR MEDICARE &	VIEDICAID SERVICES				CIVID IVO	<u>. 0930-0391</u>	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 06/26/2024		
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				43	9 BELLEVUE AVENUE			
BELLE CA	RE NURSING AND REH	ABILITATION CENTER						
			IF	RENTON, NJ 08618				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658	Continued From page	: 64	F 6	58				
F 000	Continued From page 64 reach out to the Agencies to determine the staff provided. On 6/25/24 at 10:21 AM, the surveyor interviewed the staffing in the presence of the staffing sheets needed to be maintained and kept as a reference at all times. The stated the unit managers kept records of the assignment sheets, but the sheets cannot be located. The acknowledged her role was to oversee the nursing department, and confirmed the staffing levels were not acceptable. On 6/25/24 at 10:21 AM, the surveyor requested the Medication Administration Record with the times medication was administered for five sampled residents (Resident #32, #43, #60, #250, and #252) for the time period of through surveyor with Administration Documentation Audit Detail Report (ADADR) for the weeks of to stated Resident #252 was discharged from the facility in stated Resident #252 was discharged from the facility in stated Resident #252 was discharged from the facility at the time, so she provided the week of the surveyor stated Resident #252 was discharged from the facility at the time, so she provided the week of the surveyor stated Resident #252 was discharged from the facility at the time, so she provided the week of the surveyor stated Resident #252 was discharged from the facility at the time, so she provided the week of the surveyor stated Resident #252 was discharged from the facility at the time, so she provided the week of the surveyor stated Resident #252 was discharged from the facility at the time, so she provided the week of the surveyor stated Resident #252 was discharged from the facility at the time, so she provided the week of the week of the surveyor stated Resident #252 was discharged from the facility at the time, so she provided the week of the week of the surveyor stated Resident #252 was discharged from the facility at the time, so she provided the week of the week of the surveyor stated Resident #252 was discharged from the facility at the time.		F 6	.58	for 3 months will be conducted on 5 resident Medication administration records by the Director of Nursing/Designee to assure that reside are receiving their medications as order and that medications that are discontinued are no longer listed on the medication administration record. A weekly audit for 4 week and monthly 3 months will be conducted by the director of rehab therapy/designee on 5 resident to determine compliance with orders being consistent in POS, TAR, Care PI Element 4: Monitoring/ Quality Assurant The results of the weekly will be submit to the Quality Assurance and Process Improvement Committee Meeting month for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	for ctor nts an.		
	the who stated a administered as order medication, dose, rou continued medication	te, and time. The was to be administered at one hour before or after						

The surveyor reviewed the ADADR reports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			5 111110		С			
		315124	B. WING			06/	26/2024	
NAME OF PROVIDER OR SUPPLIER BELLE CARE NURSING AND REHABILITATION CENTER		ABILITATION CENTER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 139 BELLEVUE AVENUE IRENTON, NJ 08618			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658	For the weeks of For Resident #32, the administered out of the 8:00 AM dose on NJ doses on NJ Exec O for the 6:00 PM dose dose on Scheduled at 4:00 PM NJ Exec Order 26 It was also that their 8:00 AM me at 2:04 PM; and their AM medications were For Resident #60, the administered out of the 8:00 AM doses on NJ for the 1:00 PM doses for the 5:00 PM doses	through were time parameters: for the Ex Order 26.4(b)(1) Exec Order 26.4(b)(1) Exec Order 26.4b1 ; for the 5:00 PM rder 26.4b1 ; for the 5:00 PM rder 26.4b1 and the 10 PM was documented the Order 26.4b1 It, was administered late on 6.4b1 documented on discorder 20, dications were administered at 1:26 PM. eir medications were time parameters: for the Exec Order 26.4b1 so on NJ Exec Order 26.4b1	F	658				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED C 06/26/2024	
		315124 B. WING _					
	ROVIDER OR SUPPLIER ARE NURSING AND R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 658	administered out of 8:00 AM dose on on NJ Exec Order 26 on NJ Exec Order 27 on 10:26 PM. For the week of NJ Resident #43's me out of the time par on NJ Exec Order 26 on NJ Exec Order 27 on NJ Exec Order 27 on NJ Exec Order 28 on NJ Exec Order 29	the time parameters: for the first the time parameters: for the for the 9:00 AM doses on 11/9/22, 4b1; and the 5:00 PM doses or 11/9/22, 4b1; and the 5:00 PM doses on 11/9/22, 4b1; and the 5:00 PM doses or 11/9/22, 4b1; and the 5:00 PM doses on 11/9/22, 4b1; and the 5:00 PM doses on 11/9/22, 4b1; and the 5:00 PM, and their were administered at 1:52 PM, and their w	F	558			

	(X3) DATE SURVEY COMPLETED C 06/26/2024	
315124 B. WING		
NAME OF PROVIDER OR SUPPLIER BELLE CARE NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	3/20/2024	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated Feffected a brief interview for mental status (BIMS) score of sour tof 15, which indicated a NJ Exec Order 26.4b1 A review of the Order Summary Report reflected an active order, dated of source order, dated of source order		

		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 06/26/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 439 BELLEVUE AVENUE TRENTON, NJ 08618	DE	00/20/2024	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 658	revealed an active or NJ Exec Order 26.4b1 eve surveyor and special formula in Administration Order nurses initials identify applied today and with NJ Exec Order 26.4b1). nurses should not be was not applied. On 6/25/24 at 11:06 of the US FOIA (b) (6 that the US FOIA (b) (reviewed the cord for Resident #60, which der to apply to eryday shift, and apply left every evening shift. The entified that the Treatment also that displayed the ring that the treatment has been thin the past survey dates. The signing off on the order if it ed a copy of the order that is signed off by the physician PM. AM, the US FOIA (b)(6) in the presence of the survey team confirmed that is should have been even and that the nurses was applied when it was provide any policy regarding ysician's orders and/oring the treatment	F6	658			
F 677 SS=D	NJAC 8:39-11.2(b); 2 ADL Care Provided for	7.1(a) or Dependent Residents	F 6	577		8/25/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDI	FRUCTION	(X3) DATE SURVEY COMPLETED			
		315124	B. WING	B. WING			C 06/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		CIENCY MUST BE PRECEDED BY FULL PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 677	out activities of daily services to maintain of personal and oral hyd. This REQUIREMENT by: Complaint #: NJ 159 Based on observation pertinent facility document facility failed care was provided for observed during #32 and Resident #1. provided during active residents 2 of 4 residents 2 of 4 residents 2 of 4 resident #60 and Resident #60 and Resident #147 was at the diagnoses which NJ Exec Order 20 comprehensive Minimassessment tool date Resident #147 had and was #147's individualized (ICCP) reflected that	dent who is unable to carry living receives the necessary good nutrition, grooming, and giene; is not met as evidenced 451 In, interview, and review of ments, it was determined to ensure a.) If 2 out of 7 residents Tourder 26,451 Tourder 26,451 Tourder 47) and b.) If was evidenced by the Idmission Record (AR), differenced by the Idmission Record (AR), differenced by the Idmission Record (AR), and the facility with included but not limited to 6,451 In The num Data Set (MDS), an and If we was evidenced that I was evidented to the facility with included but not limited to 6,451 In the num Data Set (MDS), an and I we was evidenced that I was evidented that I was ev	F	#73 On initial staff Bow Res On initial care resid Eler All r affee Ele On initial staff Bow Res Unitial staff	ADL Care Provided for pendent Residents ment 1: dident #32 and #147 received care. For residents #60 and acree was perf1xormed. June 21, 2024, the Unit Manager ated re-education to all clinical nurse from the policy and procedure for yel and Bladder Incontinence Care ident Care grooming (nail care). July 25, 2024, the DON/designee water an audit to assure incontinence and nail care is being provided to dents during activities of daily livingment 2: Identification of at-Risk Are esidents have the potential to be coted by this practice. The policy and procedure for yel and Bladder Incontinence Care ident Care grooming/nail care. Eakly audits for the next 4 weeks an anthly for the next 3 months of 5 of dents on each unit will be conducted the unit manager and/or designee the ure that incontinence care and nail as is being provided during activities.	sing and vill g. as sing and d		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 06/26/2024	
NAME OF P	ROVIDER OR SUPPLIER	0.0.2.		STREET ADDRESS, CITY, STATE, ZIP CO		6/26/2024	
TO THE OT THE	TO VIDER OR GOLF EIER			439 BELLEVUE AVENUE	002		
BELLE CARE NURSING AND REHABILITATION CENTER				TRENTON, NJ 08618			
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F 677	Continued From page	e 70	F 6	577			
	to the facility with the but not limited to NJ E comprehensive MDS Resident #32 had NJ was NJ Exception on star #32's ICCP reflected resident NJ Exec Order 26.451 cand that the resident and NJ Exec Order.			Element 4: Monitoring/ Qualify The results of the weekly at be submitted to the Quality Process Improvement Commonthly for 4 months. Base results of these audits, a demade regarding the need for submission and reporting.	nd monthly will Assurance and mittee Meeting ed on the ecision will be		
	an NJ Exec Order 26.4b1 tour of unit accompanied by	M, the surveyor conducted on the NJ Exectorder 26:451 nursing the Unit Manager/Licensed LPN #1) and observed the					
	#147's room who was UM/LPN #1 asked the their NJ Exec Order 26.4b1 UM/LPN #1 permission that the resident's NJ the NJ Exec Order under the resident was sheet located under to contained some NJ Exec Order 26.4b1 the contained some NJ Exec #1 identified as NJ Exec #1 was interviewed at the US FOIA (b) (60 assigned to care for FNJ Exec Order 26.4b1) care and NJ Exec Order 26.4b1 out M/LPN #1 stated the cared for the resident	at Les corder 2 like which UM/LPN which UM/LPN to Corder 26.4b1 UM/LPN to this time and stated that that has sheet when performing dishould not have left a					

		IDENTIFICATION NUMBER:		riple construction	(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 06/26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP 439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE	33/20/202
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B	
F 677	came in this morning not made rounds ye not made rounds ye rounds every two hours. The resident's durin. NJ Exec Order 26.4bil resident's durin. On 6/18/24 at 8:45 A an Secondar 26.4bil tour unit with a Licensed observed the following observed the following the following of the time and confirm observed with a secondar 26.4bil of the time and confirm observed on the resident's sentire bed linen show to care for Resident rounds that morning unit and checked the residents were resident's bed linens import to ensure that it is sentire bed linens import to ensure that the country that the country to ensure that the country to ensure that the country to ensure that the country that the country to ensure that the country that the count	use the CNA (CNA #1) that g just got to the unit and had t. UM/LPN #1 stated that should be done by the CNA e surveyor observed the g the tour and the resident's 16.4b1. AM, the surveyor conducted on the resident unursing Practical Nurse (LPN #1) and ng: Yeyor accompanied LPN #1 2's room observed the and the resident was ident's brief was observed to and the sheets were ecorder 26.4b1 that had a 1 LPN #1 was interviewed at led that the resident was ident's sheet was 1 LPN #1 was interviewed at led that the resident was ident's sheet was 1 LPN #1 was interviewed at led that the resident was 1 LPN #1 was interviewed at led that the resident was 1 LPN #1 was interviewed at led that the resident was 1 LPN #1 was interviewed at led that the resident's was 1 LPN #1 was interviewed at led that the resident was 1 LPN #1 was interviewed at led that the resident's was 2 Should have made when she had arrived to the residents to see if any	F			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315124	B. WING		C 06/26/2024
	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		1 00/20/2027		
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETION
F 677	CNA #2 who stated morning and perform for Resident #32. Conducted rounds of and did not see the resident's bed sheet was NJ Exec Order 26.4 resident's and that it On 6/19/24 at 9:08 // CNA #1 who stated should be checked was important to ass NJ Exec Order 26.4b1 when the resident was on was important to ass NJ Exec Order 26.4b1 when the resident when the resident when the resident when the resident was the unit, she made in the previous shift so the residents were stated that breakfas residents should be start their meals. On 6/20/24 at 9:55 // the US FOIA (b)	AM, the surveyor interviewed that she made rounds that ned an NJ Exec Order 26.4b1 NA #2 stated that she nesident #32 in the dark, NJ Exec Order 26.4b1 on the so or notice the resident's or notice the residents or not frequently because the or notice that residents' or notice that residents' or not he bed because leaving the head because leaving the head because leaving the notice of the bed because leaving the notice of the head that when she arrived on ounds with the CNAs from that she could ensure that all the surveyor interviewed at 8:00 AM, so not execorder 26.4b1. CNA #1 The could be done when staff ensure that any priority	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3	(X3) DATE SURVEY COMPLETED	
		315124	B. WING				C 06/26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REF	HABILITATION CENTER		439 B	ET ADDRESS, CITY, STATE, ZIP CODE ELLEVUE AVENUE ITON, NJ 08618		00/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 677	them, and en when stated that clear top of stated that clear top of stated that residents should be to ensure that residents should be to ensure that residents are timed to ensure that residents. The stated that clear top of stated that clear top	identify Net Construction residents, residents, residents, got onto the should be should not be put on stated that all checked on every two hours into were provided nely because residents left. AM, th US FOIA (b)(6) In the presence of stated that all checked on every two hours into the put on the should not be put on stated that all checked on every two hours into the provided nely because residents left. AM, th US FOIA (b)(6) In the presence of the operation of the put of th	F	577			
	NUExec order 25.451 as NUExec or are have been NUExec Resident #73 denied	21 AM, the surveyor 73 in their room with their ad Wester When asked if their corder 26.4b1 by the facility, and voiced that they do not ould like them					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED		
		315124	B. WING _			C 06/26/2024		
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP O 439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE	00/20/2021		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 677	Resident #73 the Resident #73. The surveyor review Resident #73. A review of the Orthat Resident #73 diagnosis that incling NJ Exec Order A review of the moderate of the MDS and Set (MDS), a status (BIMS) scoindicated a NJ Exection NJ Exec Order A review of the inclination o	der Summary Report revealed was admitted to the facility with uded, but not limited to 26.4b1 Dest recent quarterly Minimum an assessment tool dated brief interview for mental re of out of 15, which wec Order 26.4b1 Exec Order 26.4b1 Dividualized comprehensive care ded a focus area dated lities of daily living (ADL) 26.4b1 With Subsciolar 28.4b1 Dividualized comprehensive care ded a focus area dated lities of daily living (ADL) 26.4b1 With Subsciolar 28.4b1 Dividualized comprehensive care ded a focus area dated lities of daily living (ADL) 26.4b1 With Subsciolar 28.4b1 Dividualized comprehensive care ded a focus area dated lities of daily living (ADL) 26.4b1 With Subsciolar 28.4b1 With Subsciolar 28.4b1 Dividualized comprehensive care dated lities of daily living (ADL) 26.4b1 With Subsciolar 28.4b1 Dividualized comprehensive care dated lities of daily living (ADL) 27.4b1 With Subsciolar 28.4b1 With Subsciolar 28.4b1 Dividualized comprehensive care dated lities of daily living (ADL) 28.4b1 With Subsciolar 28.4b1 Dividualized comprehensive care dated lities of daily living (ADL) 29.4c2 Can AM, the surveyor interviewed lities care, which included	F	677				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 06/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REF	ABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 439 BELLEVUE AVENUE TRENTON, NJ 08618	DE		
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F 677	responded, further were completed by the nurse during checked for the nurse and survey team ack expectation of the fac completed on the research of the nurse of the nurse were and nails have been Resident #60 denied the nurse of the Admiration summary) admitted to the facility included, but not limit the nurse of the most the nurse of the	with underneath also or explained that weekly by in which were not be solded and weekly by in which were not be solded and weekly by in which were not be solded and weekly by in which were not be solded and weekly by in which were not be solded and weekly by were	F	577			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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On 6/19/24 at 10:20 Al CNA #2 and #3 who be were responsible for the weekly who stated that responsible for were supposed to responded, were supposed to responded, were complete weekly by the nurse dowere checked for time, Resident #60 app station, and the survey and were checked for time, Resident #60 app station, and the survey and NUESCOTOR 26-05 and UM/LPN # NUESCOTOR 26-05 and unacces of the the Number of the confirmed that number of the num	M, the surveyor interviewed of the confirmed that they which included by Exec Order 26.4b1. M, the surveyor interviewed of the confirmed that they which included by Exec Order 26.4b1. M, the surveyor interviewed of the CNAs were asked how residents' appear, the surveyor interviewed of the CNAs were asked how residents' appear, the surveyor and which are asked how residents' appear, the surveyor and which are asked that they were explained that they were that their were care was an at should have been as. The surveyor informed that theo's were with the surveyor and UM/LPN	F	677			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		OATE SURVEY COMPLETED
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F 677	On 6/26/24 at 10:35 and survey team ack expectation of the fac completed on the rest of the facility of the f	AM, the US FOIA (b)(6) Innowledged that it was the cility that care was sidents. It is "Resident Careted last reviewed January rim the nails using the nail and the tips of the nails. 7. Inder the nails using a lab. Essential Points: the vide observation and care of on bath day as needed It is undated "Certified Nurse nent included5. Bathes the or shower, combs hair, cleans and gives shampoos22. Its and families receive the vice in a caring and esphere which recognizes the lad right It is undated "Licensed tion" document included9. Indicates nursing personnel in lent care in adherence with julations. 10. Ensures that its receive the highest quality	F6	577		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	IABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	1 33/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 677	Continued From pag		F 67	7	
F 686	included4. Assesse nursing personnel as description, unit stan the individual6. Er perform their jobs to NJAC 8:39-27.2 (g)	rse Position" document es the work performance of	F 68	6	8/25/24
SS=D	CFR(s): 483.25(b)(1) §483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the compre resident, the facility r (i) A resident receive professional standard pressure ulcers and ulcers unless the ind demonstrates that th (ii) A resident with pro necessary treatment with professional stan promote healing, pre new ulcers from deve	grity grity gree ulcers. The energy eassessment of a grown of a gr			0,20,2
	Based on observation pertinent facility document that the facility failed order for NJ Exec Complement the individual plan (ICCP) intervention on a deficient practice was	on, interviews, and review of aments, it was determined to a.) obtain a physician's order 26.4b1 and b.) dualized comprehensive care tion to use a resident's bed. This is identified for 1 of 1 resident order 26.4b1 (Resident #9),		During the initial tour of the facility by surveyors it was identified that staff f to obtain a physician order followed and did not implement the individualized comprehensive caplan (ICCP) intervention to use a on resident # 9 \(\text{s} \) s bed .	ailed ^{225,412} ent

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		315124	B. WING				26/2024	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
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BLLLL CA	THE HORSING AND IN	INABILITATION CENTER		TF	RENTON, NJ 08618			
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F 686	Continued From pa and was evidenced On 6/17/24 at 10:54 facility, the surveyor in bed. The resident which was placed a connected to an into the power outled. On 6/19/24 at 11:05 Resident #9's bed was not present at 100 Market Was not present at 1	by the following: AM, during initial tour of the robserved Resident #9 lying twas on a regular mattress top NJ Exec Order 26.4b1 which was that was not plugged to roturned on. AM, the surveyor observed which contained a regular with bed linens placed on top of er 26.4b1. The resident the time of observation. AM, the surveyor interviewed (6) ed, Resident #9 was being ec Order 26.4b1 which was now resolved. Wed the resident's ICCP with dentified that the resident was ing at risk for NJ Exec Order 26.4b1, it for a NJ Exec Order 26.4b1 with dentified that the resident was ing at risk for NJ Exec Order 26.4b1 with dentified that the resident was ing at risk for NJ Exec Order 26.4b1 with dentified that the resident was ing at risk for NJ Exec Order 26.4b1 with dentified that the resident was ing at risk for NJ Exec Order 26.4b1. The resident did not have the resi		6386	The West order 26.461 was removed due to the resident #9 Seconder 26.461 being resolve. The order and care plan were discontinued. On June 20, 2024, the Assistant Direct of Nursing initiated re-education to the licensed nursing staff on obtaining a physician order for a New Example of and initiation of a individualized comprehensive care plan. On July 25, 2024, the unit managers or each unit will initiate an audit for reside with skin altercations requiring a pressure ducing device on their bed to assure that they are in place with an associate care plan and order. Element 2: Identification of at-Risk Area All residents have the potential to be affected by this practice. Element 3: Systemic Change On July 25, 2024, the Director of Nursin will initiate re-education to the Unit Managers and US FOIA (b)(6) on obtaining a physician order a pressure reducing device and initiation of an individualized comprehensive carplan.	he ed. or nts ure d as		
	in bed for the	The US FOIA (b)(6) e was NJ Exec Order 26.4b1 e resident; that the NJ Exec h the regular mattress was			Unit manager and/or designee will conduct weekly audits of all residents skin altercations requiring a pressure reducing device on their bed to assure that they are in place with an associate			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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BELLE CA	ARE NURSING AND RE	HABILITATION CENTER		Т	RENTON, NJ 08618		
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F 686	Continued From page The surveyor review Resident #9. A review of the Adm admission summary admitted to the facili included NJ Exec A review of the curre Report did not included NJ Exec Order A review of the ICCF NJ Exec Order 26.451 with the use of NJ Exec Chair. A review of the most chair. A review of the most chair.	ge 80 yed the medical record for ission Record face sheet (an) indicated the resident was ty with diagnosis which Order 26.4b1 ent Physician Order Summary de a physician's order for use		586		nce	DAIL
	On 6/20/24 at 10:34 survey team, the sur US FOIA (b)(6) Resident #9 had his that the resident sho	AM, in the presence of the rveyor interviewed the) confirmed that tory of NJ Exec Order 26.4b1 and buld be on a NJ Exec Order 26.4b1 and set to the resident's NJ Exec Order 26.4b1 and buld be on a NJ Exec Order 26.4b1 and set to the resident's NJ Exec Order 26.4b1 and bull be on a NJ Exec Order					

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F 686	how the resident's be regular mattress atop which the state and that she had "new don't use it this washould not have a regular state and that she had "new defeats the purpose" On 6/26/24 at 10:46 apresence of the surve if Resident #9 hys execution of the surve should have be resulted by the should have be resulted and pressure reduction so wheelchair per the faselection Algorithm. "Wound Prevention and obtain orders for treatment protocol	d was arranged with a a NJ Exec Order 26.4b1, to d that was "unacceptable" wer seen that done this way, ay." She further stated "we gular mattress on top, it [of the NJ Exec Order 26.4b1] AM, the surveyor, in the ey team, US FOIA (b)(6) and an order for use of a 4b1 on the bed, to which the d "No" and the No" and the een one." s "Wound Prevention and the reviewed March 2024, cer PreventionProvide a surface for bed and/ or cility's Support Surface (Refer to Algorithm of this	F6	86		
F 693 SS=D	CFR(s): 483.25(g)(4) §483.25(g)(4)-(5) Ent (Includes naso-gastri both percutaneous en percutaneous endoscenteral fluids). Based	reral Nutrition c and gastrostomy tubes, ndoscopic gastrostomy and copic jejunostomy, and	F 6	93		8/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 693	eat enough alone enteral methods used condition demons clinically indicated resident; and §483.25(g)(5) A resident; and §483.25(g)(5) A resident resident; and §483.25(g)(5) A resident to prevent coincluding but not I diarrhea, vomiting abnormalities, and This REQUIREMED by: Based on observing pertinent facility diather the facility fair administer physician's orders identified for 1 of the following: On 6/17/24 at 10: Resident #32 lying near their bed. The being administered the surveyor if the Resident #32 sho On 6/19/24 at 10:		F	be administered at 14:00 interfere with the administ NIExec Order 26:451. As a result of investigation by the nursin was determined that the redisconnected the per day to administer the That was contributed of NIExec Order 26:451 order is now or 1400 hours at NIExec Order 26:451	vas changed to so that it did not tration times for of the ng department, it nurses 126.451 three times NJ Exec Order 26.451 outing to the time on. The current nee per day at er 26.451 when connected. The ental of the literature of interese of the ental of the literature of the ental of the literature.		

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NAME OF P	ROVIDER OR SUPPLIER	315124	B. WING		TREET ADDRESS. CITY. STATE. ZIP CODE	06/2	26/2024
	ARE NURSING AND REH	ABILITATION CENTER		43	39 BELLEVUE AVENUE RENTON, NJ 08618		
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F 693	The NJ Exec Order 26.4b1 The Surveyor at 7:30 PM. On 6/19/24 at 12:30 N Resident #32 lying in administering NJ Execution The surveyor reviewer Resident #32. According to the Adm (admission summary to facility with diagnormal summary to facil	was labeled as hung on PM, the surveyor observed bed with the COrder 26.4b1 an COrder 26.4b1 an COrder 26.4b1 an COrder 26.4b1 and CORDER	F	693	procedure for Enteral Feeding inclusive ensuring the total volume administered consistent with the physician sorder. On July 25, 2024, the unit manager and designee will initiate an audit of all residents with tube feeding orders to assure that the volume to be administe in accordance to the physician sorder. This will be completed by July 26, 2024 Element 2: Identification of at-Risk Area All residents with tube feeding have the potential to be affected by this practice. Element 3: Systemic Change The DON/designee will do a weekly auby 4 weeks and monthly by 3 months of all residents with tube feeding orders to assure that the volume to be administe is in accordance with the physician sorder. The Registered Dietician will conduct a monthly audit by 3 months of residents with an order for enteral feeding to ensure the orders are input correctly. Element 4: Monitoring/ Quality Assurant. The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee monthly for 3 months. Bas on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	is d/or red . d. dit f ored red	

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F 693	plan (ICCP) dated estinctuded that the restinctuded that the result included to monitor status included a polymer stat	vidualized comprehensive care effective state of the present, sident required a related to need for the present, sident required a related to need for the present, sident required a related to need for the present of	F	993				

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
BELLE CA	ARE NURSING AND REI	ABILITATION CENTER	439 BELLEVUE AVENUE TRENTON, NJ 08618					
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F 693	Continued From pag Signed on the eMAR but the nurs at the On 6/19/24 at 12:30 accompanied the sur room, and they obse the NJ Exec Order stated that Resident completed around 10 the nurse who chang cleared the which the STOIA (b)(6) Co The surveyor asked received since the at 4 PM, and the not say for certain if the at 4 PM, and the not say for certain if the The STOIA (b)(6) also acc would continue to ad reached a NJ Exec take approximately of the started a acknowledged it was could have received the NJ Exec Order 26.451 could have sees Order 26.451 could have nearby nurse to NJ Exec	e 85 also stated that the nurse when they started the when they started the es did not document the es did not document the end of each shift. PM, the started the end of each shift. PM, the started the started that the resident in bed with the started that the resident in bed with the started that the resident that the resident that the resident was started on the started that the resident was started on the started that the resident was started on the started that the resident would the started that the resident that the resident that the resident that the resident word that the resident that the resident word that the resident more than started to the resident that the resi						
	the US FOIA (b) (c resident's was physician's orders; the administered at the ti) who stated that a according to the						

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F 693	adminis responded, the was NJ Exec Order the nurse document was started, but the adminis surveyor then asked Resident #32 received NJ Exec Order 26.4b1, if indicated NJ Exec stated that she could received the ordered should have document they held the been communicated On 6/26/24 at 10:35 presence of the US an through interviews w "assuming" the the nurse should be making rounds on the acknowledged the fadiligent in tracking w and how much the nurse should have the nurse signed the spoke to staff but did the spoke to staff	the facility monitored the stered each shift, the stered each shift, the stered each shift, the stered each shift. The stered each shift amount of at 12:30 PM, the stered each shift in the resident stered in the Progress Notes if and why, and it should have to the next shift. AM, the stered in the stered shift. AM, the stered in the stered shift. AM, the stered in the stered shift in the stered shift. AM, the stered shift in the stered shift in the stered shift should have been checking and e units. The stered shift, and we documented if the stered shift, and we documented if the stated that she verbally in the facility conducted an stated that she verbally in the stered shift in the stated that she verbally in the stated t	F	693			

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	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	33/23/2021	
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F 693	dated revised 5/1/11, Document administra Medication Administra including: Date, Form bolus. 17. Document formula and water flux Output Record if appl following, including, b placement verification	y's "Enteral Feeding" policy included Procedure: [] 16. tion of feeding on ation Record (MAR) ula, Rate and Continuous total intake separated into sh on MAR or Intake & icable. 18. Document the ut not limited to: Tube n, Time tube feeding tient tolerance, and Amount	F 69	93		
F 697 SS=E	provided to residents consistent with profes the comprehensive per and the residents' goar This REQUIREMENT by: NJ Complaint #1667 Based on interview and documents, it was defailed to ensure a resimal management a.) medications as order resident's was be	who require such services, ssional standards of practice, erson-centered care plan, als and preferences. is not met as evidenced and review of pertinent facility termined that the facility ident who received daily received their and b.) ensure the	F 69	Element 1: Corrective Actions Resident #97 no longer resides in the facility. Based on observation, intervie and review of the facility documents it identified for resident #97 that the fac failed to administer medication p physician orders and to ensure that the resident s is assessed every shappy in the factor of the fa	ew, t was illity er ne	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		riple NG _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER ARE NURSING AND REF	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		1 00/	23/2024	
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F 697	identified for 1 of 1 residents reviewed for management (Resident #97), and was evidenced by the following: On 6/20/24 at 9:23 AM, the surveyor reviewed the		F	697	On July 26, 2024, the Director of Nursing will initiate re-education to the licensed nursing staff on the policy and procedu for Pain Management. On July 26, 2024, the DON/designee winitiate an audit to assure residents with	re		
	A review of the Residual admission summary) admitted to the facilit	d medical record for Resident #97. liew of the Resident Face Sheet (an ession summary) reflected the resident was exted to the facility with diagnoses which ded NJ Exec Order 26.4b1 liew of the individualized comprehensive care (ICCP) included a focus area dated with a goal to be free from with a goal to be free from and rentions which included assess for signs and toms of NJESSEO ORDER 20.4b1			pain medication orders are administered per physician orders. On July 26, 2024, the DON/designee with initiate an audit to assure that residents with documented pain and/or pain medication orders are assessed for paid every shift. The nurses who were identified to not provide the ordered mediation will	ed vill s in be		
	plan (ICCP) included for with a goal to interventions which is symptoms of through assessing are dated NJ Exec Order 26.4 an NJ Exec Order				by the Director of Nursing/designee regarding if an ordered medication not available, that the nurse should not the physician and get an alternate order for a medication to treat the medication to treat the medication arrives. On July 26, 2024, the director of nursing/designee will initiate an audit to assure that all ordered pain medication were available. Element 2: Identification of at-Risk Area All residents have the potential to be affected by this practice.	n is ify er until		
	A review of the Administration Recorphysician's order (PCNJ Exec Order 26	d (MAR) revealed a			Element 3: Systemic Change Weekly audits will be completed by unimanager and/or designee on each unit			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		1 001	20/2027	
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F 697	1:00 PM; and 5:00 F corresponding admin following: On 6/22/24 at 9:00 A administered see last A review of the corresponding administered and contain administered and contain administered and contain at 7:53 PM, that the the hospital at 4:30 F. The next NN was daincluded the resident was observed in include why the resident was observed in include why the resident was observed in include why the resident was in included the review on the corresponding during the 7:00 AM to resident was in included at 12:00 A review of the dated of the corresponding during the 7:00 AM to resident was in included at 12:00 A review of the dated of the da	Scheduled at 9:00 AM; M. A review of the nistration times revealed the state of the nistration times revealed from at 9:00 AM, state of the nistration of the nistra	F	697	5 residents with pain medication order assure that are administered per physician orders. Weekly audits will be completed by unimanager and/or designee on each unit 5 residents with documented pain and/pain medication orders are assessed for pain every shift. Element 4: Monitoring/ Quality Assurant The results of the weekly will be submit to the Quality Assurance and Process Improvement Committee Meeting monifor 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	t of or or nce		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315124	B. WING				C / 26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618			20,2027	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIE		3E	(X5) COMPLETION DATE	
F 697	indicated on awaiting medication PM, the resident wa no documentation for dose. A further review of the Programment of the Programment of the Programment of the Programment of the Pharmacy to be awaiting a prescription before, and nurse can formation who der nurse documented the additional note date resident was out of the pharmacy of the pharmacy of the pharmacy to be awaiting a prescription before, and nurse can formation who der nurse documented the additional note date resident was out of the pharmacy of the pharmacy of the pharmacy of the pharmacy to be awaiting a prescription before, and nurse can formation who der nurse documented the additional note date resident was out of the pharmacy of the pharma	esponding last section at 12:00 AM and 6:00 AM, from pharmacy, and at 12:00 s not in the facility. There was or the MERCOCOMOTE at 6:00 AM The Subsection of the facility at 9:05 AM to go to A to de last of the facility at 9:05 AM and 6:00 The Progress Notes did not not not the physician or so why the resident	F	597				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315124	B. WING _			06/2) 26/2024		
	ROVIDER OR SUPPLIER ARE NURSING AND REF	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 439 BELLEVUE AVENUE TRENTON, NJ 08618	DE	,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA		(X5) COMPLETION DATE		
F 697	Set (MDS) dated had a brief interview score of a out of A fur resident received rou. On 6/20/24 at 9:36 A the US FOIA (b)(6) was monitored for all a scale every shresident did not received. The backup scale every shresident did not received. The backup declining in the inventory revealed At this time, the surveyor request of the inventory revealed At this time, the surveyor request information for what surveyor request information for what scale; and the resident's considerable declining in the surveyor request information for what scale; and the resident's Scale; and the resident S	prehensive Minimum Data and prevaled the resident for mental status (BIMS) 15, which indicated a president review revealed the attine who stated who stated who stated who stated if the sidents on the MAR using the stated if the sidents on the MAR using the documented why it was not stated the facility had a sident of stated the facility had a sident of supply, but review of a stated the facility had a sident of supply, but review of a stated the resident's was not included. The surveyor requested the resident's ventory sheets for sident's ventory sheets for sident's was done for those shifts; the sident's was done for those shifts; the sident's wentory sheets. My the surveyor in the conditional was done for those shifts; the sident's wentory sheets. My the surveyor in the conditional was done for those shifts; the sident's wentory sheets. My the surveyor in the conditional was done for those shifts; the sident's wentory sheets. My the surveyor in the conditional was done for those shifts; the sident's wentory sheets. My the surveyor in the conditional was done for those shifts; the sident's wentory sheets. My the surveyor received the Patient was conditional was done for those shifts; the surveyor received the Patient was conditional was conditional was conditional was done for those shifts; the surveyor received the Patient was conditional was conditional was conditional was conditional was conditional was done for those shifts; the surveyor received the Patient was conditional was cond	F	697					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		315124	B. WING _			C 06/26/2024		
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE	00/20/2024		
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F 697	PM. There were no a sheets. On 6/26/24 at 10:35 A and survey team state locate any additional for any additional information of the resident's acknowledged the fact the resident was on important to monitor the medication prescribed. At that time, the had at the time not received. A review of the facility policy dated reviewed the facility must ensu provided to residents consistent with profess practice, the comprehences and the respreferences are gularly based on face.	at 12:00 additional declining inventory AM US FOIA (b)(6) and they were unable to declining inventory sheets was unable to provide ation regarding the missing medication should be red. The street of the sheet o	F	697				

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		315124	B. WING _			C 06/26/2024		
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F 697	Continued From pa		F 6			9/25/24		
F 725 SS=E	Sufficient Nursing S CFR(s): 483.35(a)		F 7	25		8/25/24		
	the appropriate con provide nursing and resident safety and practicable physica well-being of each resident assessment and considering the diagnoses of the fa	nt Staff. ve sufficient nursing staff with inpetencies and skills sets to direct related services to assure attain or maintain the highest direct, and psychosocial resident, as determined by ints and individual plans of care in number, acuity and cility's resident population in the facility assessment required						
	by sufficient number types of personnel nursing care to all r resident care plans (i) Except when wa this section, license	ived under paragraph (e) of ed nurses; and ersonnel, including but not						
	paragraph (e) of thi designate a license nurse on each tour This REQUIREMEN by: Based on observat pertinent facility door that the facility faile staff to ensure resid	pt when waived under s section, the facility must d nurse to serve as a charge of duty. NT is not met as evidenced ion, interview, and review of cuments, it was determined d to provide sufficient nursing lents were provided with care nest practical wellbeing by		Element 1 In an effort to ensure addition added to facility staffing, the working proactively in hiring sable to be compliant with staf	facility is staff to be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		315124	B. WING _				C 26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	IABILITATION CENTER		439 BE	T ADDRESS, CITY, STATE, ZIP CODE ELLEVUE AVENUE TON, NJ 08618	1 00.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 725	#147) and b.) medica according to physicia residents reviewed for timing (Resident #32 deficient practice was Refer F658 and F677 1. According to the A Resident #147 was at the diagnoses which NJ Exec Order 20 recent comprehensive an assessment tool of Resident #147 had and was #147's individualized (ICCP) reflected that with NJ Exec Order 26.4b According to the AR, to the facility with the but not limited to NJ most recent comprehensive and was Resident #32's ICCP provided NJ Exec Order 26.4b and that the resident and NJ Exec Order 26.4b On 6/18/24 at 8:02 A	care was 7 residents observed during (Resident #32 and Resident ations were administered in's orders for 4 of 4 or medication administration in, #43, #60, and #250). This is evidenced by the following: dmission Record (AR), idmitted to the facility with included but not limited to 6.4b1 The most is e Minimum Data Set (MDS), idated The most is e Minimum Data Set (MDS), idated The most is e Minimum Data Set (MDS), idated The most is e Minimum Data Set (MDS), idated The most is e Minimum Data Set (MDS), idated The most is e Minimum Data Set (MDS), idated The most is e Minimum Data Set (MDS), idated The most is e Minimum Data Set (MDS), idated The most is e Minimum Data Set (MDS), idated The most is e Minimum Data Set (MDS), idated The most is e Minimum Data Set (MDS), idated The most is evidented that The most is eviden	F 7	recepture for the recepture for the recepture for the forest for the forest for the forest forest for the forest f	quirements. Additional staff are beind cruited utilizing the following including the not limited to generous sign on muses, shift differential pay, addition affing agency contracts, job postings sultiple job recruiting sites and job fair tements 2 residents have the potential to be feeted by this practice. The administrator/Designee will monited aff schedules on a daily basis for ampliance. The iministrator will in-service on the requirement for staff the nursing home. The Administrator / Designee will and the nurse staffing schedules on a daily sis for two months to monitor mpliance. The results of the daily audits will be be bounded to the Quality Assurance and occess Improvement Committee monitor 2 months. Based on the results of the eading the need for continued bounded by the need for continued bounded by the need for continued bounded to the portion.	g nal non rs. or ffing lit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE
F 725	Practical Nurse (Um/following: The surveyor and UM#147's room who wa UM/LPN #1 asked th their NJ Exec Order 26.4b' UM/LPN #1 permissi that the resident's NJ the NJ Exec Order 26.4b' the NJ Exec Order 26.4b' the contained some NJ Exec Order 26.4b' the resident's the resident or the resident or the resident shift must have left the resident's bed because ame in that morning not made rounds yet NJ Exec Order 26.4b' rounds every two hours. The resident's NJ Exec Order 26.4b' or UM/LPN #1 stated the cared for the resident shift must have left the resident's bed because in that morning not made rounds yet NJ Exec Order 26.4b' or UM/LPN #1 stated the cared for the resident's or UM/LPN #1 stated the cared for the resident's or UM/LPN #1 stated the cared for the resident's or UM/LPN #1 stated the cared for the resident's or UM/LPN #1 stated the cared for the resident's or UM/LPN #1 stated the cared for the resident's or UM/LPN #1 stated the cared for the resident's or UM/LPN #1 stated the cared for the resident's or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated the cared for the resident or UM/LPN #1 stated	the Unit Manager/Licensed LPN #1) and observed the M/LPN #1 entered Resident sobserved lying in bed. e resident if she could check and the resident gave on. The surveyor observed Exec Order 26.4b1 and 26.4b1 that was directly as however the fitted the Use of had a large at the Use of had a large and which UM/LPN as that time, and stated that be that time, and stated that be sheet when performing d should not have left a on the resident's bed. The ton 11:00 PM to 7:00 AM are used to the unit and had a UM/LPN #1 stated that were completed by the CNA as surveyor observed the of the tour and the resident's	F7	725			
	thirteen assigned res						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		315124	B. WING _			C 06/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		•	1 00/20/2024	
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F 725	observed the residence observed to be were observed with NJ Exec Order 26.4b1 at the time and configure observed of the time and configure observed of the time and configure of the time and that the residual have been linen should have been was observed, and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and away. UM/LPN #2 for the stated that CNA #2 Resident #32 should morning when she had checked the resident were NJ Exec Order 26.4b1 and away. UM/LPN #2 (Resident #32 was bed linens. UM/LPN assure that the resident that	A (b) (6) AM, the surveyor into Resident #32's room not lying in bed and was ident's NJ Exec Order 26.4b1 was dec Order 26.4b1 and the sheets and NJ Exec Order 26.4b1 that had a . The standard was interviewed firmed that the NJ Exec Order 26.4b1 and the resident's sheet was sident's NJ Exec Order 26.4b1 and the entire bed and the entire bed and the resident's was der 26.4b1. AM, the surveyor interviewed was assigned to care for the have made rounds that and arrived at the unit and the standard was assigned to why including the resident's was including the resident's #2 stated it was import to lents were including the residents was and to keep residents. Assignment sheet for at for the resident census of assigned CNAs. CNA #2 had	F 7:	25			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _				26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 439 BELLEVUE AVENUE TRENTON, NJ 08618	ODE	, 00/.	· · · · · · · · · · · · · · · · · · ·
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F 725	the CNA #2 who state that morning and per check for Resident # did not see the NJ Exec bed sheets and did r NJ Exec Order 2 she did not turn the I room. CNA #2 state NJ Exec Order 26.4b1 are been NJ Exec Order 26.4b1 are sident was on NJ Exec Order 26.4b1 are bed line on the bed NJ Exec Order 26.4b1, and to put clean bed line who have the stated that when made rounds with the shift so that she coul residents were NJ Exec Order 26.4b1, and to put clean bed line who have the line of the bed NJ Exec Order 26.4b1, and to put clean bed line who have the line of the line of the line of the bed NJ Exec Order 26.4b1, and the line of the line	and that she made rounds formed an STENCO Order 26.4b1 and the resident's on the resident's because ight on in the resident's detail the residents detail the residents detail the residents detail the resident detail	F.	725			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, , ,	(X3) DATE SURVEY COMPLETED	
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F 725	responsibility was to ensure that the bed linen were emphasizing that the linen, then the stated that of top of stated that of top of linen, checked on every that it was important it was unacceptable. On 6/25/24 at 10: who stated she so accordance with sone CNA to every shift; one CNA for evening shift; and residents for the control of the contro	shift rounds, the staffs to identify state of the identify residents and residents were when when staff and interested in the idean linen should be stated in the idean linen should not be put on and all residents should be two hours. The state residents were at risk for were at risk for state regulation which required a record to each to every ten residents for the idean covernight shift. The state required to the idean to every hard to find staff; it not always meet the required and survey team acknowledged on the idea of the i	F	725			
		e conference on 6/17/24 at					

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		`		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
F 725	US FOIA (b)(6) the stated that Agency staffing. At requested the Nurse completed for the w On 6/18/24 at 11:56 surveyor that the fact records for 2022; the information from the surveyor asked the maintain staffing reconfirmed the facility. On 6/25/24 at 10:13 the Nurse Staffing Formster the facility for 11/6/2 revealed the following the facility for 11/6/2 revealed the following the facility for 11/6/2, there would not a total of four not twenty-four hour performs that total of four not twenty-four hour performs that total of four not twenty-four hour performs that total of the work with a total of three twenty-four hour performs that the state of three twenty-four hour performs the state of t	ow the facility's staff was, and at the facility relied heavily on that time, the surveyor a Staffing Report to be eeks of 11/6/22 to 11/19/22. AM, the surveyor informed the cility did not have the staffing at they were trying to get the payroll company. The staffing if the facility needed to cords, and the surveyor reviewed the port sheets completed by 12 through 11/19/22 which are a census of 91 residents curses throughout the riod. as a census of 91 residents curses throughout the riod with no nurses on the sar a census of 93 residents curses throughout the riod. as a census of 93 residents curses throughout the riod. as a census of 93 residents curses throughout the riod. as a census of 93 residents curses throughout the riod. as a census of 93 residents curses throughout the riod.	F 7	725						
	with a total of four retwenty-four hour per On 11/11/22, there	vas a census of 93 residents esidents throughout the riod. vas a census of 92 residents urses throughout the								

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	, 33,23,232	
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F 725	with a total of three twenty-four hour per evening shift. On 11/14/22, there with a total of two not twenty-four hour per evening shift. On 11/15/22, there with a total of twe not twenty-four hour per overnight shift. On 11/15/22, there with a total of three twenty-four hour per evening shift. On 11/16/22, there with a total of three twenty-four hour per evening shift. On 11/17/22, there with a total of two not twenty-four hour per evening shift. On 11/18/22, there with a total of one not twenty-four hour per evening shifts. On 11/19/22, there with a total of one not twenty-four hour per or evening shifts. At that time, the could not locate the sheets, and they us complete the staffing	vas a census of 93 residents nurses throughout the riod. vas a census of 93 residents urses throughout the riod with no nurses on the vas a census of 94 residents urses throughout the riod with no nurses on the vas a census of 95 residents nurses throughout the riod. vas a census of 95 residents nurses throughout the riod with no nurses on the vas a census of 95 residents nurses throughout the riod with no nurses on the vas a census of 93 residents urse throughout the riod with no nurse on the vas a census of 94 residents urse throughout the riod with no nurses on the day vas a census of 93 residents urse throughout the riod with no nurse on the day vas a census of 93 residents urse throughout the riod with no nurse on the day vas a census of 93 residents urse throughout the riod with no nurse on the day vas a census of 93 residents urse throughout the riod with no nurse on the day vas a census of 93 residents urse throughout the riod with no nurse on the day vas a census of 93 residents urse throughout the riod with no nurse on the day vas a census of 93 residents urse throughout the riod with no nurse on the day vas a census of 93 residents urse throughout the riod with no nurse on the day vas a census of 93 residents urse throughout the riod with no nurse on the day vas a census of 93 residents urse throughout the riod with no nurse on the day vas a census of 93 residents urse throughout the riod with no nurse on the day vas a census of 93 residents urse throughout the riod with no nurse on the day vas a census of 93 residents urse throughout the riod with no nurse on the day vas a census of 94 residents urse throughout the riod with no nurse on the day vas a census of 93 residents urse throughout the riod with no nurse on the day vas a census of 93 residents urse throughout the riod with no nurse on the day vas a census of 95 residents urse throughout the riod with no nurse on the day vas a census of 95 residents urse throughout the riod with no nurse on the day vas a census of 95 residents urse throughout	F 72	25		

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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
F 725	who stated sh and could not locate time. The US FOIA (b) (6) reach out to the Ager provided. On 6/25/24 at 10:21 the SPOIA (b) (6) staffing sheets needs as a reference at all unit managers kept resheets, but the sheet acknowledged nursing department, levels were not acce. At that time, the surve Medication Administre medication was admiresidents (Resident of #252) for the time per surveyor with Adminid Detail Report (ADAD for Residents).	e was not here at the time, the staffing sheets for that (b)(6) stated she could noies to determine the staff AM, the surveyor interviewed ence of the staff and who acknowledged the ed to be maintained and kept times. The stated the ecords of the assignment the cannot be located. The her role was to oversee the and confirmed the staffing ptable. The staffing problem is the staffing ptable. The staffing ptable in the staffing ptab	F	725		
	On 6/25/24 at 1:30 P the stated administered as order	and Resident #43 was ne time so she provided the M, the surveyor interviewed medication should be ered; the right person, ute, and time. The state of the surveyor interviewed medication should be ered; the right person,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 06/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE	00/20/2027	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 725	the time prescribed the medication was the medication was a that their 8:00 AM at 2:04 PM; and the AM medications we for the 1:00 PM doses on doses on NJ Exect Exception was a that their 8:00 AM at 2:04 PM; and the AM medications we for the 1:00 PM doses on doses on NJ Exect Exception was a that their 8:00 AM at 2:04 PM; and the AM medications we for Resident #60, administered out on 8:00 AM doses on NJ Exect Exception PM doses On	ion was to be administered at d or one hour before or after is timed for. Ewed the ADADR reports realed the following: IJ Exec Order 26.4b1: their medications were if the time parameters: for the important for the 9:00 AM doses on 26.4b1 if for the 9:00 AM doses on 26.4b1 if for the 5:00 PM c Order 26.4b1 if for the 5:00 PM c Order 26.4b1 if for the 5:00 PM c Order 26.4b1 See on See order 26.4b1 PM, was administered the c Order 26.4b1 PM, was administered late on 26.4b1 So documented on See order 26.4b1 Iso documented on See order 26.4b1 The important is see order 26.4b1 The important is seed to the important is seed to be a	F7	725			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		315124	B. WING			C		
NAME OF P	ROVIDER OR SUPPLIER	313124		STREET ADDRESS, CITY, STATE	•	06/26/2024		
TO THE OT T	NOVIDEN ON COLL FEET			439 BELLEVUE AVENUE	, 2.11 0002			
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER		TRENTON, NJ 08618				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
F 725	9:00 PM doses on Name of the series of the s	J Exec Order 26.4b1 documented that they 9:00 AM medications at neir medications were the time parameters: for the Exec Order 26.4b1 1:00 PM doses on ; and the 5:00 PM doses 26.4b1 It was dent's 9:00 AM doses on stered at 1:52 PM, and their were administered at Exec Order 26.4b1,	F 7	725				
	Resident #43's medic out of the time param on the time param of the 6:00 PM dose on documented the 9:00 administered at 12:00 On 6/26/24 at 10:30 additional staffing for through 11/19/22, who there were three nurs for the overnight; on nurses for the day ar for the evening; on 1 nurses for the evening overnight shifts; on 1 day shift, two for the overnight shifts; on 1 the day, three for the overnight shift; for 11	cations were administered leters: for the 9:00 AM dose PM dose on Section 2007 2007; and Section 2007 2007 2007 2007 2007 2007 2007 200						

	FEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315124	B. WING _			C
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	l	06/26/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 725	for the day four for the overnight; for 11/13/2 day, two for the ever overnight; for 11/14/2 evening and one for and 11/16/22 there vovernight; 11/17/22 there wovernight; 11/17/22 there wovernight; 11/17/22 there wovernight; and for 11 evening and one for On 6/26/24 at 10:34 acknowledged these A review of the facilit Incontinence Care" pincluded that control incontinent residents infection control proground the spread of A review of the facility Staff" policy dated la included it is the polisufficient staff with a skill sets to assure remaintain the highest and psychosocial we The facility's census resident population with facility assessments of the second of the policy of the facility of the	In/12/22 there were two nurses the evening, and two for the 22 there was three for the sing, and one for the 22 there was two for the the overnight; for 11/15/22 was two for the evening and there were three for the the overnight; for 11/18/22 the evening and one for the /19/22 there were two for the the overnight. AM, the Secondary and Bladder colicy dated May 2023, ling common infections for a was part of the overall gramthe facility was ng a safe a healthy dents and to minimize or of infections Ay's "Nursing and Sufficient st reviewed July 2023, cy of this facility to provide propriate competencies and esident safety and attain or practicable physical, mental, ell-being of each resident., acuity and diagnoses of the will be considered based on entthe facility will supply feach of the following a 24-hour basis to provide sidents in accordance with	F 7	725		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315124	B. WING		06/26/2024		
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION		
F 725	Continued From pag	e 105	F 72	5			
	NJAC 8:39-25.2 (a); Pharmacy Srvcs/Pro CFR(s): 483.45(a)(b)	cedures/Pharmacist/Records	F 75	5	8/25/24		
	drugs and biologicals them under an agree §483.70(g). The fac personnel to adminis	vide routine and emergency s to its residents, or obtain					
	pharmaceutical servi that assure the accu dispensing, and adm	res. A facility must provide ices (including procedures rate acquiring, receiving, inistering of all drugs and the needs of each resident.					
		Consultation. The facility in the services of a licensed					
		les consultation on all ion of pharmacy services in					
		ishes a system of records of on of all controlled drugs in able an accurate					
	order and that an accis maintained and pe	mines that drug records are in count of all controlled drugs criodically reconciled. T is not met as evidenced					

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR NC). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
						С	
		315124	B. WING _			06/	26/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DELLE CA	DE NUBEING AND DEU	ADU ITATION CENTED		43	39 BELLEVUE AVENUE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER		T	RENTON, NJ 08618		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
			-				
F 755	Continued From page	e 106	F 7	755			
	by:						
		n, interview, and review of			Element 1: Corrective Actions		
	'	ments, it was determined					
		to provide pharmaceutical			Resident #89 had their medication		
	services in accordance				administration reviewed to ensure		
	standards by not ens				accurate documentation of medication		
		dication administration			administration. Resident #32 their medication		
		edication administration esidents by 1 of 2 nurses; b.)			administration reviewed to ensure		
		ion of the administration of a			accurate documentation of medication		
	medication (NJ Exec Order 26.4	according to physician's			administration.		
	orders from NJ Exec Order 26	intil surveyor inquiry; c.)			Resident #61 their medication		
	accurate inventory do	ocumentation of a NJ Exec Order 26.461			administration reviewed to ensure		
	medication (NJ Exec Order 2	^{6.4b1} administered on			accurate documentation of medication		
	NJ Exec Order 2; d.) maintain	accurate documentation for			administration.		
	signing the NJ Exec Order	shift-to-shift inventory			Resident #79their medication		
	counts of the	medications on the			administration reviewed to ensure		
	morning shift of 6/18/				accurate documentation of medication		
		medication administration			administration.		
	observation and an a				Resident #51 their medication		
	for one 1 of 2 medica	ation carts inspected; and e.)			administration reviewed to ensure		
		shift count logs were			accurate documentation of medication		
	accurately account fo	nce with facility policy and			administration. Resident #84their medication		
		or and document the medications identified			administration reviewed to ensure		
		carts and was evidenced by			accurate documentation of medication		
	the following:	darts and was evidenced by			administration.		
					Residents #5 had their medication		
	Reference: New Jers	ey Statutes Annotated, Title			administration reviewed to ensure		
	45. Chapter 11. Nursi	ing Board. The Nurse			accurate documentation of NJ EX Order 26.4(b)(1		
		tate of New Jersey states:			medication including accurate		
	"The practice of nursi				documentation and signing the	4(b)(1	
		defined as diagnosing and			shift to shift declining inventory	_	
		onses to actual and potential			count sheet.		
	' '	al health problems, through			Resident #51 had their medication		
		e finding, health teaching,			administration reviewed to ensure		
	health counseling, an				accurate documentation of		
	supportive to or resto	rative of life and wellbeing,			medication including accurate		

and executing medical regimens as prescribed by

documentation and signing the NJEX OTGGT 25-4(D)(1

CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		7 BOILDIN			С
	315124	B. WING _		06	5/26/2024
OVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE		
RE NURSING AND REF	IARII ITATION CENTER		439 BELLEVUE AVENUE		
KE NOKOMO AND KEI	IABIETIATION SENTEN		TRENTON, NJ 08618		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
Continued From pag	e 107	F 7	55		
			shift to shift declining inventors count sheet.	ory	
45, Chapter 11. Nurs Practice Act for the S "The practice of nurs nurse is defined as p responsibilities withir finding; reinforcing the program through heacounseling and proving restorative care, und registered nurse or liauthorized physician. The deficient practice following: 1. On 6/18/24 at 7:57 administration observed the Registe electronic signatures.	sing Board. The Nurse State of New Jersey states: sing as a licensed practical performing tasks and in the framework of case the patient and family teaching alth teaching, health sion of supportive and er the direction of a censed or otherwise legally or dentist." The AM, during the medication vation, the surveyor ered Nurse (RN #1) entering for the medications that she		All residents have the potential to affected by this practice. Element 3: Systemic Change On June 18, 2024, the Director of initiated re-education to the licens nursing staff on the Policy and Promedication Administration and Sc Controlled Substance Medication. On July 26, 2024, the Director of I will initiate a weekly audit by 4 we monthly by 3 months to assess the controlled substances are documentary and signed out for the administrate Schedule II Controlled Substance accordance with physician orders monitor the narcotic declining she the nursing staff are signing out the	Nursing ed ocedure hedule II Nursing eks and at all ented ion of in to ets that ie	
electronic Medication (eMAR). On 6/18/24 at 8:13 A borrow a password", using the login passw Manager/Licensed P because she was an a problem with her log on 6/18/24 at 8:21 A RN #1 entering elect	Administration Record M, RN #1 stated "I had to explaining that she was word for the Unit tractical Nurse (UM/LPN #1) The state of the Unit tractical Nurse, and she had origin. M, the surveyor observed ronic signatures for the 8:00		change. On July 26, 2024, the Director of I will initiate re-education to the to do in person medical passes on the nurses. On July 26, 2024, the Director of I will initiate re-education to the total that all nursing staff have their own credentials to log into the staff of the process of	Nursing OIA (b) (6) ation Nursing (a (b) (6) o ensure n	
	SUMMARY S' (EACH DEFICIENCE REGULATORY OR Continued From page a licensed or otherwiphysician or dentist." Reference: New Jers 45, Chapter 11. Nurs Practice Act for the S' "The practice of nurs nurse is defined as presponsibilities withir finding; reinforcing the program through heat counseling and proving restorative care, und registered nurse or liauthorized physician authorized physician The deficient practice following: 1. On 6/18/24 at 7:57 administration observed the Registe electronic signatures had administered to electronic Medication (eMAR). On 6/18/24 at 8:13 A borrow a password", using the login passive Manager/Licensed Phecause she was an a problem with her login for the login with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login passive Manager/Licensed Phecause she was an a problem with her login	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 107 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 practices were evidenced by the following: 1. On 6/18/24 at 7:57 AM, during the medication administration observation, the surveyor observed the Registered Nurse (RN #1) entering electronic signatures for the medications that she had administered to Resident #89 in the electronic Medication Administration Record (eMAR). On 6/18/24 at 8:13 AM, RN #1 stated "I had to borrow a password", explaining that she was using the login password for the Unit Manager/Licensed Practical Nurse (UM/LPN #1) because she was an increase of the surveyor observed RN #1 entering electronic signatures for the 8:00 AM (8 AM) and 9:00 AM (9 AM) medications for	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 107 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 practices were evidenced by the following: 1. On 6/18/24 at 7:57 AM, during the medication administration observation, the surveyor observed the Registered Nurse (RN #1) entering electronic signatures for the medications that she had administered to Resident #89 in the electronic Medication Administration Record (eMAR). On 6/18/24 at 8:13 AM, RN #1 stated "I had to borrow a password", explaining that she was using the login password for the Unit Manager/Licensed Practical Nurse (UM/LPN #1) because she was an authorized in nurse, and she had a problem with her login. On 6/18/24 at 8:21 AM, the surveyor observed RN #1 entering electronic signatures for the 8:00	STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 107 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 restorative care, under the direction of a restorative care, under the medications administration observation, the surveyor observed the Registered Nurse (RN #1) entering electronic Signatures for the medications that she had administered to Resident #89 in the electronic Medication Administration Record (eMARR). On 6/18/24 at 8:13 AM, RN #1 stated "I had to borrow a password", explaining that she was using the login password for the Unit Manager/Licensed Practical Nurse (UM/LPN #1) because she was an murse, and she had a problem with her login. SITRET ADDRESS, CITY, STATE, ZIP CODE TRENTON, NJ 08618 TRENTON, N	STREET ADDRESS, CITY, STATE, 2IP CODE 439 BELLEVUE AVENUE TRENTON, NJ 98618 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 107 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 practices were evidenced by the following: The deficient practices were evidenced by the following: The deficient practice were evidenced by the following: On 6/18/24 at 7:57 AM, during the medication administration observation, the surveyor observed the Registered Nurse (RN #1) entering electronic signatures for the medications that she had administerate to Resident #89 in the electronic Medication Administration Record (eMAR). On 6/18/24 at 8:13 AM, RN #1 stated "I had to borrow a password", explaining that she was using the login password for the Unit Manager/Licensed Practical Nurse (UM/LPN #1) because she was an 1 On 6/18/24 at 8:21 AM, the surveyor observed RN #1 entering electronic signatures for the 3:00 AM (8 AM) and 9:00 AM (9 AM) medications for

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		315124	B. WING _				C 26/2024
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
				43	39 BELLEVUE AVENUE		
BELLE CA	RE NURSING AND REF	IABILITATION CENTER		TRENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	#1 stated that she had morning medications needed to sign the elements where administered more residents earlier becausince the residents with or had NJ chance to sign the elements of had NJ chance to sign the elements of had needed to sign the elements of had needed to sign the elements of had needed to had a sign of had needed to had a sign of had needed to had a sign of had needed to had given RN #1 was a problem this man and had given RN #1 was a problem this man and had given RN #1 was a problem this man and had given RN #1 was a problem this man and had given RN #1 was a problem this man and had given RN #1 was a problem this man and had given RN #1 was a problem this man and had given RN #1 stated that medical immediately after adding had been supported by had been supported	sampled residents, t #1, #2, #3, #4, #5, #6). RN and already administered the to those residents and MAR. RN #1 explained that wrining medications to the ause they were a priority were either to make they were a priority on the same	F 7	755	On June 21, 2024, the Director of Nursinitiated re-education to licensed nursir staff on documenting on the Methadon Chain of Custody Record. On June 21, 2024, the Director of Nursinitiated re-education to the nursing stato report the nursing supervisor immediately of any discrepancies with Schedule II Controlled Substance Medications. On June 21, 2024, the Director of Nursinitiated re-education to the nursing stathat pre-signing for Scheduled II Controlled Substance Medication is prohibited. On June 21, 2024, the Director of Nursinitiated re-education to the nursing stathat a declining inventory sheet will be provided with each dispensed prescript for controlled dangerous medication in addition to proper procedure for chartin of medications, the nurse must docume on the declining inventory sheet the darent of administration, the quantity administered, the amount of medication remaining, and his/her initials. An inventory count of all controlled danger substances medications stored on each nursing unit shall be performed at each change of each shift by both the income and outgoing nurse. Both nurses are responsible for the count and must sign the narcotic count form. On June 18, 2024, the Director of Nursing the narcotic count form.	ing ing iff ing iff ing iff tion ig ent te n ous n ing	
	were trained on how	to use the system, but that			the narcotic count form.		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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		315124	B. WING			1	26/2024
NAME OF P	ROVIDER OR SUPPLIER		-	S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				43	39 BELLEVUE AVENUE		
BELLE CA	ARE NURSING AND REI	HABILITATION CENTER		т	RENTON, NJ 08618		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	l	PROVIDER'S PLAN OF CORRECTIO	1	(X5)
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
	1		+				
F 755	0	400	_				
F 755	Continued From pag	le 109	F	755			
	0 0/40/04 / 40 40	D			nursing staff on the Policy and Proce		
	On 6/18/24 at 12:12				Medication Administration and Sched	ule II	
	interviewed the US	who stated that she was			Controlled Substance Medication.		
	rosponsible for provi	ding the login passwords for			A monthly guidit will be conducted for	2	
	the agency purson	The Sport by also stated that			A monthly audit will be conducted for months by the Unit Managers/Design		
		own login password, and			the following: that a declining invento		
		RN #1's login password at			sheet will be provided with each	у	
		g, but that RN #1 had			dispensed prescription for controlled		
	1	d wrong three times and was			dangerous medication; proper proced	ure	
	locked out.				for documenting on the declining		
					inventory sheet the date of administra	tion,	
	On 6/19/24 at 8:30 A	M, the surveyor interviewed			the quantity administered, the amoun		
) who stated that			medication remaining, and his/her ini	ials.	
		r own login password and			An inventory count shall be performe	d of	
		ther nurse's login. The			all controlled dangerous substances		
	1	#1 should not have given her			stored on each nursing unit at each		
		N #1 because the login			change of each shift by both the inco	ning	
		nurse's signature. The			and outgoing nurse. Both nurses are		
		dministrative staff which			responsible for the count and must si	gn	
		I the capability to unlock the a new one. The strong also			the narcotic count form.		
		e a new one. The also also uter system was changed on			Element 4: Monitoring/ Quality Assura	nco	
		sing procedures were still to			Lientent 4. Monitoring/ Quality Assur	IIICE	
		explained that the eMAR			The results of the monthly audits will	ne.	
	was to be signed imi	•			submitted to the Quality Assurance a		
	medication was adm				Process Improvement Committee		
					monthly for 3 months. Based on the		
	On 6/19/24 at 3:50 F	PM, the surveyor interviewed			results of these audits, a decision will	be	
	the US FOIA (b)(6	via the telephone			made regarding the need for continue	ed	
	who stated that she	had started as the ^{us fol} in			submission and reporting.		
		she had not done any					
	1	n nurses or inservices for					
	medication administr	ration yet.					
	On 6/20/24 -t 4:04 5	ONA the cumiou to consider					
		PM, the survey team met with					
	the and the	FOIA (b)(6) stated that there					
		Stated that there			1		1

were no medication administration observations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 6/26/2024	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, 439 BELLEVUE AVENUE TRENTON, NJ 08618		012012024	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 755	performed with RN done any inservice recently. A review of the fac Administration Poli that after medication necessary medical information (e.g. (for are administered, prefused medication).	#1, and the facility had not es on medication administration	F7	755			
	medication adminisobserved RN #2 pt Resident #5 which	:59 AM, during the morning stration pass, the surveyor, reparing medications for included a NJ Exec Order 26.4b1					
	RN #2 administer #5 which included Upon returning to the surveyor observed	the MJ Exec Order 26.4b1 tablet. the medication cart, the RN #2 electronically sign the t #5 for all the highlighted					
	Resident #5. A review of the Adı	wed the medical record for mission Record face sheet ary) revealed diagnoses that order 26.4b1					

AND BLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		315124	B. WING			06/26/2	2024
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER	,	STREET ADDRESS, CIT 439 BELLEVUE AVEN TRENTON, NJ 086	NUE	1 00/20/2	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CC	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRI DEFICIENCY)	_	(X5) DMPLETION DATE
F 755	A review of the Order a physician's order (NJESCO OF A) For NJ Exec Order and with NJESCO OF A NJESCO	er Summary Report revealed PO) with a start date of der 26.4b1 tablet, give 1 tablet by for NJ Exec Order 26.4b1. Give Exec Order 26.4b1 . Give Exec Order 26.4b1 active date of NJ Exec Order 26.4b1 tablet; we times a day for level order grade for a total dose of NJ Exec Order 26.4b1 tablet; we times a day for level order grade for a total dose of NJ Exec Order 26.4b1 in addition, the eMAR level order grade for a total leve	F	755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		315124	B. WING _			C 06/26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 439 BELLEVUE AVENUE TRENTON, NJ 08618	E	
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F 755	entered incorrectly be date of with the with the linstructions regarding when the electronic sthe NJ Exec Order 26.4b highlighted for admin line of the PO was entered in the PO	ecause the PO had a start should have been started on Rec Order 26.4b1 PO. UM/LPN Exec Order 26.4b1 PO had a the total dose, but that ystem started on dose would not be stration at 9 AM until was unable to speak to how incorrectly. Sous computer system evealed a PO dated by Exec Order 26.4b1; by oral route 2 times per long for a total of long together at 9 AM for a long together at 9 AM for a long together at 9 AM for a long together long for long together long for long together long to	F 7	755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	315124	B. WING		C 06/26/2024	
NAME OF PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CO 439 BELLEVUE AVENUE TRENTON, NJ 08618		
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Administration" included prior to each medication is the RIGHT DI RIGHT ROUTE RIGHT TIME, for that the MAR reorder 3. On 6/18/24 a RN #1 preparing Resident #51 w NJEXOLORIFIZATION WAS SUPERIOR OF 26.461 was inventory sheet was inventory sheet was clinic and had to resident for the bottles were retreated and the that there were Resident #51. Record and the that there were Resident #51. Reand three contains was inventory sheet was clinic and had to resident for the bottles were retreated and the that there were Resident #51. Record and the that there contains was inventored and the that there were Resident #51. Reand three contains was inventored and the that there were Resident #51. Record and the that there contains was inventored and the that there were Resident #51. Record and three contains was inventored and the that there were Resident #51. Record and three contains was inventored and the that there were Resident #51. Record and three contains was inventored and the that there were Resident #51. Record and three contains was inventored and the that there were Resident #51. Record and three contains was inventored and the that there were Resident #51. Record and three contains was inventored and the that there were Resident #51. Record and three contains was inventored and the three were Resident #51. Record and three contains was inventored and the three were Resident #51. Record and three contains was inventored and the three were Resident #51.	facility's "Medication policy dated effective 12/23/23, or medication administration Verify in preparation that the medication RUG, at the RIGHT DOSE, the part the RIGHT RATE, at the part the RIGHT CUSTOMERVerify at the RIGHT CUSTOMERVerify a	F 75	55		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 06/26/2024	
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	US FOIA (b)(6) supposed to sign the #51 stated that they the #51 stated that they the supposed to sign the #51 stated that they the signing. A review of the eMAF administration card of administration card of the medication card of unsure about administration card of the medication card of unsure about administration card of the medication card of unsure about administration card of the medication card of unsure about administration card of unsure about administration card of the medication card of unsure about administration card of the medication card of the medication card of the medication card of the supposed for Resident states and the supposed for the removal of the supposed for the removal of the supposed for the removal of the supposed for the supposed	tated that she thought the) was form on Secondaria Resident hought they had taken their and had not remembered Refor Resident #51 for ation on Secondaria revealed are of the Secondaria revealed are of the Secondaria revealed by that she was the nurse on a secondaria The was stering Secondaria to briveyor with the s	F 7	755			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		315124	B. WING				26/ 2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	l		43	TREET ADDRESS, CITY, STATE, ZIP CODE 39 BELLEVUE AVENUE RENTON, NJ 08618	1 00//	20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	amount of medication initials 4. On 6/18/24 at 8:44 RN #1 preparing to a Resident #51 which in the supervisors from the weekly basis. RN #1 was a process of the weekly basis. RN #1 was a process of the weekly basis. RN #1 was a process of the weekly basis. RN #1 was a process of the weekly basis. RN #1 was process of the weekly basis. RN #1 was process of the process of the weekly basis. RN #1 was process of the resident for the approcess of the resident for the approcess of the resident #51. The Rempty and three contents and signing the record RN #1 stated that she and signing the record RN #1	The eet the date of transity administered, the aremaining and his/her To AM, the surveyor observed diminister medications to included the surveyor observed clinic on a explained that the and had an explained that the and had an explained by the nurse and the object of the surveyor order 26.4b1 wided by the nurse and the object of the clinic. The seven bottles in a bag for the surveyor observed dimediated that four were stained that four one bottle dimediated that four were stained that four one bottle dimediated that four were stained that four were	F	755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315124	B. WING			C 6/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 439 BELLEVUE AVENUE TRENTON, NJ 08618	•	10/20/2024	
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F 755	the Secondarian Count daily nurses' signature count of the shift) that correspond unit high side medic that the sheet was represented that the sheet was represented that the sheet was represented that the outgoing nurse, Count She sheet in front of the that she had not told supervisor about the supervi	Sheet (a monthly sheet for ures to verify the inventory at the change of at the change of atton cart, which revealed not signed for the ated that she had done an the beginning of her shift with but had forgotten to sign the et and proceeded to sign the surveyor. RN #1 then stated do the surveyor. RN #1 then stated do the surveyor is signature for the et missing signature for the ry because there was no	F 7	55			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315124	B. WING			C 6/26/2024	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CC 439 BELLEVUE AVENUE TRENTON, NJ 08618		•		
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F 755	came in for their sileaving their shift. the NEW COUNTY Count the inventory was that the NEW COUNTY	ted when the incoming nurse nift and the outgoing nurse was The further explained that it sheet should be signed when completed. The stated count Sheets should be ted meaning there were no in, the stated that if there incies, then that should be rvisor immediately. The system prevented any in occurring with the system occurring	F 75	55			
	presence of RN #1 nursing unit high s logs. The following The "Jexes Order 25.45" shi Sheet", RN #1 pre outgoing nurse. The "Individual Pa	ide medication cart's Westeronaria I was observed: ift-to-shift ' ^{NJEsser Order 28} Count -signed for the ^{NJEsser} 3 PM					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	8	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		315124	B. WING			06/	26/2024
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At that time, confirmed sportion of the have pre-sign sheet was to outgoing nure complete contogether. Represented the individual on 6/18/24 presence of nursing unit logs. The form Resident #9 (NJ Exect log was mist documentated and the individual on 6/18/24 UM/LPN #2 missing documentary log on 6/18/24 UM/LPN #2 missing documentary log on 6/19/24 the statement of the individual of the individual on 6/19/24 the statement of the individual on 6/19/24 the statement of the individual on 6/19/24 the statement of the individual of the individual on 6/19/24 the statement of the individual	was miles or the surve he had presented info to be signed reserved by #1 furthing signatural patiental patiental patient high side illowing with the side in for the who state umentations.	sing "Nurse Administering" 9 AM and 9 PM doses. eyor interviewed RN #1, who re-signed the outgoing nurse shift stating "I shouldn't rming the surveyor that this red by the incoming and ther at shift change after a had been performed er stated that there should ures or documentation on Necrotorial National Residual Indiana (Indiana) I	F	755			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				MPLETED
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F 755	shifts; 7 AM to 3 PM, to 7 AM. The second was completed comes in for their shift was leaving their shift Sheet should be sign completed. In addition discrepancies then the supervisor immediate individual resident be signed when the from inventory so that discrepancies. Review of the facility' Controlled Substance declining inventory sheach dispensed president administered, in additional charting of medication document on the decidate of administration the amount of medical initials. An inventory stored on each nursine each change of each and outgoing nurse. If	as PM to 11 PM and 11 PM applained that the inventory when the incoming nurse and the outgoing nurse and the outgoing nurse and the outgoing nurse and the inventory count ed when the inventory at should be reported to a cally. The outgoing added that the sheets were to sheets were to was removed at there were no outgoing and the outgoing and th	F7	755		
F 756 SS=F	Drug Regimen Revie	9.2 (a)(d), 29.4(k), 29.7(c) w, Report Irregular, Act On (2)(4)(5)	F 7	756		8/25/24
	, , , ,	imen Review. ug regimen of each resident east once a month by a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		10/20/2024		
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F 756	§483.45(c)(4) The prirregularities to the arfacility's medical dire and these reports mu (i) Irregularities including that meets the c (d) of this section for (ii) Any irregularities during this review mu separate, written repattending physician adirector and director minimum, the resident and the irregularity th (iii) The attending phresident's medical reirregularity has been action has been take be no change in the physician should doot the resident's medical section for the resident's medical form and the irregularity has been action has been take be no change in the physician should doot the resident's medical section for the resident's medical section has been take be no change in the physician should doot the resident's medical section for the physician should doot the resident's medical section for the physician should doot the resident's medical section for the physician should doot the resident's medical section for the physician should doot the resident's medical section for the physician should doot the resident's medical section for the physician should doot the resident's medical section for the physician should doot the resident's medical section for the physician should doot the resident's medical section for the physician should doot the resident's medical section for the physician should doot the resident's medical section for the physician should doot the resident's medical section for the physician should be physician shoul	eview must include a review ical chart. Inarmacist must report any tending physician and the ctor and director of nursing, ust be acted upon. Ide, but are not limited to, any criteria set forth in paragraph an unnecessary drug. Inoted by the pharmacist ust be documented on a cort that is sent to the and the facility's medical of nursing and lists, at a not's name, the relevant drug, he pharmacist identified. In yesician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending sument his or her rationale in	F 7	56				
	This REQUIREMEN by: Based on interview a determined that the f	n to protect the resident. I is not met as evidenced and record review it was facility failed to address the face by the DISTOIA (D)(6)		F756 □ Drug Regimen Reviev Irregular Element 1: Corrective Actions	w, Report			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 756	deficient practice was residents reviewed (Resident #34, Resi Resident #61) and was facility's last standar evidence was as fol Refer F865 1. On 6/19/24 at 1:2 from the US FOIA recommendations for until present. According to the Ad Resident #34 was a diagnoses which incomplete with the quarterly Minimassessment tool day resident had NJ Executivities of daily living On 6/20/24 at 9:00 was surveyor with Resident recommendation resident had NJ Executivities of daily living Con 6/20/24 at 9:00 was surveyor with Resident had NJ Executivities of daily living Con 6/20/24 at 9:00 was surveyor with Resident had NJ Executivities of daily living Con 6/20/24 at 9:00 was surveyor with Resident had NJ Executivities of daily living Con 6/20/24 at 9:00 was surveyor with Residence of the medication should be NJ Executive administering. This	a timely manner. This as identified for 4 of 5 for medication management dent #80, Resident #60, and was previously cited during the rd survey on 10/20/22. The lows: 77 PM, the surveyor requested (b)(6) The surveyor requested the stress of the surveyor requested (b)(6) The su	F	756	For resident #34 the Pharmacy Consultant Recommendations were carried out on Consultant Recommendations must be addressed will initiate re-education to the Unit Managers and the Consultant Recommendation to the Unit Managers and the Consultant Recommendation to the Unit Managers and the Consultant Recommendations weekly by 4 weeks a monthly by 3 months to determine compliance with the Pharmacy Consultants recommendations. Element 4: Monitoring/ Quality Assurant The results of the weekly will be submit The resu	as ng /s and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED		
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				439 BELLEVUE AVENUE				
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER		TRENTON, NJ 08618				
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F 756	the use of NJ Exec Ordiagnosis for use. The Physician Order Sum recommendation was facility. The diagnosis for the use On 6/20/24 at 9:36 A the sent to the facility through the unit managers appropriate time for to be completed was receiving. The secondarions pro NJ Exec Order 20 completed until stated that the use of the Unit Manager/Lic (UM/LPN #1) for the stated that the stated that the usually completed by be assigned to the nuamongst the nursing #1 stated that an appusation week. She continued managers usually recommendations, but new electronic medic switched or secondarions. Use of the commendations. Use of the use of the commendations. Use of the use of the usually recommendations. Use of the use of the usually recommendations. Use of the use of the usually recommendations. Use of the	tition dated needed a needed a nee surveyor reviewed the mary sheet, and the continued not to have a continued not to have a me surveyor interviewed that the continued not to have a continued not to have a me surveyor interviewed that the continued not to have a continued not to have a me continued not to have a continued not explain why the could not explain why	F 7	to the Quality Assurance and Improvement Committee Me for 6 months. Based on the these audits, a decision will regarding the need for conting submission and reporting.	eting monthly results of be made			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 756	the facility's where the facility since important that the pharmacy recomm (ASAP) so that if the concern, it could be the stated that education because company was new on a "learning curv	A PM, the surveyor interviewed no stated that she had been at a facility acted upon the nendations as soon as possible nere was a medication safety the taking care of immediately. It the facility needed more the new pharmacy consultant to the facility and the staff was re".	F 7	756					
	from the US FOIA recommendations According to the A was admitted to fa NJ Exec Order According to the m Resident #80 had status (BIMS) scor	for Resident #80 from desident #80 from desident #80 cility with diagnoses included							
	of the MDS revealed diagnosis of NJ Execution media media. On 6/20/24 at 9:00 surveyor with Resi	ed the resident had an active Order 26.4b1, and received cations on a routine basis. AM, the USFOIATE provided the							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(×	(3) DATE SURVEY COMPLETED
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F 756	that the medication two tablets administered since recommended, if to consider daily, then discont recommendation with the medication include a mot completed or a secondary. The recommendation with the medication include a mot completed or a secondary. The recommendation with the medication with the medication with the medication of two tablets as needed for completed or a secondary to the mot complete do recommendation to the medication correct diagnosis of the secondary that the medication correct diagnosis of the secondary that the recommendation that the recommendation that the recommendation to the secondary that the recommendation that the recommendation that the recommendation that the medication correct diagnosis.	ndation dated NJEXEC Order 26.4b1 Exec Order 26.4b1 daily has been at the resident was NJEXEC Order 26.4b1 inue the medication. This was not completed or acted y until NJEXEC Order 26.4b1 should at the recommendation was acted upon by the facility until ndation dated NJEXEC Order 26.4b1 should at the recommendation was acted upon by the facility until ndation dated NJEXEC Order 26.4b1 order should be not some or NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order should be not seed on NJEXEC Order 26.4b1 order 26	F 7	756		

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F 756	This recommendal acted upon by the On 6/20/24 at 9:30 the sent to the facility the sent to the facility the recommendations. The recommendations on 6/20/24 at 12:30 the facility is sent to be completed with recommendations. The recommendations of the facility is sent to be completed until on 6/20/24 at 12:30 the facility is sent to the faci	from Second to NJ Exec Order 26.4b1 Ition was not completed or facility until second to the facility needed to the facility and the staff was ve".	F	756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		315124	B. WING _			C 06/26/2024		
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 439 BELLEVUE AVENUE TRENTON, NJ 08618	•	012012024		
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F 756	On 6/20/24 at 9:00 A surveyor with Reside recommendation rep The recommendation rep The recommendation rep The recommendation rep acknowledged with a facility could not provide a completed in time. The recommendation recommendation requested to do an outher results of for to be documendation administration record acknowledged with a upon review of the place of t	M, the provided the ent #60's CP orts for NJ Exec Order 26.4b1 ation dated assessment orders; ne order from services was a handwritten "done", but the vide documentation that it	F	756				
	with a handwritten "d not provide documer in timely fashion. On 6/20/24 at 9:36 A the who stated sent to the facility thr	M, the surveyor interviewed that the reports were ough email by the lations were to be completed						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 06/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REF	IABILITATION CENTER		STREET ADDRESS, CITY, STATE 439 BELLEVUE AVENUE TRENTON, NJ 08618	E, ZIP CODE	33.20.232	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)			
F 756	by the unit managers appropriate time for to be completed was receiving. The recommendations proposed in the facility's who the facility since important that the facility incompleted unit in the facility since important that the facility since	stated that an he within seven days of could not explain why the ovided from t	F	756			
	from the US FOIA (b) recommendations for until present. A review of the Admis admission summary)	Resident #61 from Session Record face sheet (an reflected that Resident #61 facility with diagnosis that Drder 26.4b1 M, the Second face sheet (an reflected that Resident #61 facility with diagnosis that Drder 26.4b1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 439 BELLEVUE AVENUE TRENTON, NJ 08618	ODE		
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F 756	requested to clarify by mouth every 12 I PM. This request we handwritten "done", (prior to surveyor in clarified until times were adjusted. The recommend requested to clarify NJ Exec Order 2 request was acknow "done", but upon resurveyor inquiry) it was continued to have the surveyor inquiry) it was acknown to be completed was acknown to be completed was acknown to be completed was acknown to the surveyor in identified to allow do the surveyo	dation dated Secondary of the MAR quiry) the order was not when the administration attending of the MAR (prior to was not updated and diagnosis. In the diagnosis for was not when the MAR (prior to was not updated and diagnosis. In the diagnosis of the MAR (prior to was not updated and diagnosis. In the diagnosis of the MAR (prior to was not updated and diagnosis. In the management of the MAR (prior to was not updated and the was not updated with a but upon review of the MAR quiry) there was no space occumentation of the resident's AM, the surveyor interviewed that the was not updated and the wa	F7	756			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		315124	B. WING _			06/	26/2024
	ROVIDER OR SUPPLIER RE NURSING AND REH	ABILITATION CENTER		43	REET ADDRESS, CITY, STATE, ZIP CODE 9 BELLEVUE AVENUE RENTON, NJ 08618		
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F 756	On 6/20/24 at 12:24 F the facility's who seems the facility since important that the face pharmacy recommen (ASAP) so that if there concern, it could be to the stated that the education because the company was new to on a "learning curve".	PM, the surveyor interviewed stated that she had been at an and it was illity acted upon the dations as soon as possible was a medication safety aking care of immediately. The facility needed more a new pharmacy consultant the facility and the staff was	F	756			
F 757 SS=D	CFR(s): 483.45(d)(1)- §483.45(d) Unnecess Each resident's drug unnecessary drugs. A drug when used- §483.45(d)(1) In exce duplicate drug therap §483.45(d)(2) For exc §483.45(d)(3) Withou §483.45(d)(4) Withou use; or §483.45(d)(5) In the p consequences which reduced or discontinu	cary Drugs-General. regimen must be free from An unnecessary drug is any ressive dose (including y); or ressive duration; or t adequate monitoring; or t adequate indications for its resence of adverse indicate the dose should be led; or	F	757			8/25/24
		mbinations of the reasons (d)(1) through (5) of this					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		315124	B. WING _			06/	26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618				
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F 757	by: Based on observation pertinent facility door that the facility failed monitoring for the use medications. This do for 4 of 5 residents is medications (Resident and was evidenced) 1. According to the Accord	IT is not met as evidenced on, interview and review of suments, it was determined of to provide adequate se of NESCO OTGET 26.451 efficient practice was identified reviewed for unneccessray ent #34, #60, #61, and #80), by the following: Admission Record (AR), dmitted to the facility with the cluded NJ Exec Order 26.451 he quarterly Minimum assessment tool dated at the resident had NJ Exec Order 26.451 he quarterly Minimum assessment tool dated at the resident had NJ Exec Order 26.451 AM, the surveyor observed I sleeping. The surveyor also I Nursing Assistant (CNA #1) at to the resident's door. CNA esident had NJ Exec Order 26.451 AM, the surveyor observed required NJ Exec Order 26.451 AM, the surveyor observed required NJ Exec Order 26.451 AM, the surveyor observed required NJ Exec Order 26.451 AM, the surveyor observed required NJ Exec Order 26.451	F	757	F757 Drug Regimen is Free from Unnecessary Drugs Element 1: Corrective Actions A review of resident #34 Medications was conducted including a documentation. A review of resident #60 Medications was conducted including a medications was conducted including a monitoring documentation. A review of resident #61 Medications was conducted including a monitoring documentation. A review of resident #80 Medications was conducted including a monitoring documentation. A review of resident #80 Medications was conducted including a monitoring documentation. On July 29, 2024, the Director of Nursing/Designee will initiate re-educate to the licensed nurses on the policy and procedure for Medication Use that behavior monitoring for all resident on antipsychotic, antianxiety, antidepressants, hypnotic medications be incorporated with the MAR monthly, monitor side effects on residents every shift, targeted behaviors to be monitored and documented, and monthly psychotropic summaries. Element 2: Identification of at-Risk Area All residents have the potential to be affected by this practice. Element 3: Systemic Change On July 29, 2024, The Director of Nursing/Designee will initiate re-educate to the licensed nurses on the policy and procedure for Medication Use that behavior monitoring for all resident on procedure for Medication Use that behavior monitoring for all resident on procedure for Medication Use that behavior monitoring for all resident on the policy and procedure for Medication Use that behavior monitoring for all resident on the policy and procedure for Medication Use that behavior monitoring for all resident on the policy and procedure for Medication Use that behavior monitoring for all resident on the policy and procedure for Medication Use that behavior monitoring for all resident on the policy and procedure for Medication Use that behavior monitoring for all resident on the policy and procedure for Medication Use that behavior monitoring for all resident on the policy and procedure for Medication Use that behavior	ion d will ed	

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NAME OF D	ROVIDER OR SUPPLIER			٥.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2024
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F 757	The surveyor reviewed Order Summary sheet Resident #34 was on medications: A physician's order (FINJ Exec Order 26.4b1) take one time a day related to the staff and when she facility staff this morn.	by a staff e resident's door. and the residents Physician et (POS) which reflected that the following STEXEC Order 26.451 PO) dated Type order 26, for 6.4b1 blet; administer 1 tablet orally d to the diagnoses of NJ Exec Order 26.4b1 tablet; give 1 tablet; give 1 te related to Type order 26.4b1 et orally two times a day NJ Exec Order 26.4b1 orally three times a day NJ Exec Order 26.4b1 orally three times a day NJ Exec Order 26.4b1 orally three times a day NJ Exec Order 26.4b1 orally three times a day NJ Exec Order 26.4b1 orally three times a day NJ Exec Order 26.4b1 orally three times a day NJ Exec Order 26.4b1 orally three times a day AM, the surveyor interviewed hat she worked for the ed that Resident #34 was and the clock because the order 26.4b1. The CNA stated are order 26.4b1 are the conder 26.4b1 at times with the received report from the ing, they told her that if the	F	757	antipsychotic, antianxiety, antidepressants, hypnotic medications be incorporated with the MAR monthly monitor side effects on residents every shift, targeted behaviors to be monitor and documented, and monthly psychotropic summaries. The Director of Nursing/Designee will audit 5 resident charts monthly times for (4) months to assure Monthly Psychotropic Summaries are completed and accurate. Element 4: Monitoring/ Quality Assurant The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee month for 4 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	ed our nce e	
		ing, they told her that if the exec Order 26.4b1, to come					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(×	(3) DATE SURVEY COMPLETED
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F 757	On 6/18/24 at 10:3 the US FOIA (b) that Resident #34 The such as a dist had not noticed on record (EMR) that documented for Re that behaviors wer Notes, however the documented on the Administration Red Administration Red Administration Red The surveyor revier TAR and there was Resident #34s NJ E On 6/18/24 at 10:3 the US FOIA (b) Floor nursing unit was on NJ Exec Order 20 That were no US FOIA (b) IS stated that exception in the Pr was no IN Exec Order 20 In that she did not kn summary was com The U.S. FOIA (NJ Exec Order 26-45) indicated NJ Exec Order 26-451 media	who stated was on NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 and atted that the facility provided rossword puzzles to occupy raction. She stated that she at the new electronic medical NJ Exec Order 26.4b1 was being esident #34. The stated was being esident #34. The stated edocumented on the Progress ere were no episodic behaviors eresident's Medication cord (MAR) or Treatment cord (TAR). Evenue the resident's MAR and so no NJ Exec Order 26.4b1 was being esident with the medical occumentation on exec Order 26.4b1 was being esident #34. Evenue the resident's MAR and so no NJ Exec Order 26.4b1 who stated that Resident #34 with the state of the residents and of the resident's with a such as other residents and of the other residents and other residents	F 7	757		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING			06/2	26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REP	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618				
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F 757	effects daily when the medical monthly Exec Order 26-453 medical monthly EMR). The surveyor recommendation was electronic medical results of the US FOIA (b) (b) behaviors were documented in the many times a reside The surveyor recommendation was a reviewed in the many times a reside The surveyor indicated that it would progress Notes. The behaviors were occur documented in the F added that side effect also be documented. On 6/20/24 at 11:24 provide the surveyor that the Surve	e resident was on tions. Please complete reviews (none found in the reliance of the followed in the resident's ecord. My the surveyor interviewed of the progress of the that have been and how an experienced a stated that there should be a complete of the progress of the that have been and how and the progress of the that there should be a complete of the progress of the that the progress of the	F	757				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		0/20/2024		
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F 757	The surveyor reviewe	ed the resident's Physician	F 7	757				
	Order Summary shee Resident #61 was on medications:	et (POS) which reflected that the following NJ Exec Order 26.451						
	A PO dated NI Exec Order 28 , 1	for NJ Exec Order 26.4b1 10 MG; In two times a day for						
		for NJ Exec Order 26.4b1 let by mouth at bedtime for 5.4b1						
	A PO dated National Property, 1	; give 1/2 tablet by						
	A PO dated tablet by mouth at be with NJ Exec Orde							
	NJ Exec Order 26 and side ef is on NJ Exec Order 26.4b1	medications and ase monitor and document 6.4b1 fects daily when the resident edications. Please complete reviews. There were none						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 06/26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 439 BELLEVUE AVENUE TRENTON, NJ 08618		00/20/2024
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F 757	The surveyor review TAR and there was Resident #61s NJ Execute US FOIA (b)(Notes. The US FOIAT) were documented in the many times a reside behavior. The monthly NJ Executed that it wou Progress Notes. The behaviors were occuded that side efferalso be documented. On 6/20/24 at 11:24 provide the surveyor that the NJ Executed that information of the No additional information. A review of the Adreflected that Reside	red the resident's MAR and documentation on ec Order 26.4b1 AM, the surveyor interviewed (a) who stated umented in the Progress and how ent experienced a targeted stated that there should be a (b) and (c)	F	757		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 757		ed the resident's POS which nt #60 was on the following	F	757					
	A PO dated Number 2 of tablet three times a constraint Number 2 of tablet 1 of								
		or NJ Exec Order 26.4b1 prally one time a day for 6.4b1							
	A PO dated give 1 tablet orally at	NJ Exec Order 26.4b1 bedtime for NJ Exec Order 26.4b1							
	A PO dated size or	NJ Exec Order 26.4b1 bedtime for NJ Exec Order 26.4b1							
	A PO dated NJExec Order 2, 1 tablet orally at bed	for NJ Exec Order 26.4b1 G; give time related to NJ Exec Order 26.4b1							
	The surveyor review TAR and there was r Resident #60s NJ Exe	ed the resident's MAR and no of the contract o							
	NJ Exec Order 2 and side e is on NJ Exec Order 26.4b1 m monthly NJ Exec Order 26.4b1 seen. The surveyor	medications and ase monitor and document 6.4b1 ffects daily when the resident edications. Please complete reviews. There were none did not find that the s followed in the resident's							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED
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F 757	the US FOIA (behaviors were do Notes. The were reviewed in many times a resibehavior. The monthly NJ Exe indicated that it were progress Notes. **Jesocologic and the added that side endocumented in the added t	2 AM, the surveyor interviewed who stated ocumented in the Progress stated that targeted behaviors the Progress Notes and how ident experienced a targeted and stated that there should be a corder 26.4b1 and ould be documented in the The stated that as the ccurring, then the behavior were e Progress Notes. The ffects from medications should ted in the Progress Notes. 24 AM, the could not yor with	F 7	757		
	#80 was admitted including but not I limited but n	most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1 most recent Minimum Data Set sment tool dated NEWSO Order 26.4b1				

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F 757	MDS Resident #80 medications on a round medication of the surveyor review observe the resident medication of the surveyor review order Summary should medicate this time. The surveyor review order Summary should medicate this time. The surveyor review order Summary should medicate this time. The surveyor review order Summary should medicate this time. The surveyor review order Summary should medicate this time. The surveyor review order Summary should medicate this time. The surveyor review order Summary should medicate this time. The surveyor review order Summary should medicate this time. The surveyor review order Summary should medicate this time. The surveyor review order Summary should medicate this time. The surveyor review order Summary should medicate this time. The surveyor review order Summary should medicate this time. The surveyor review order Summary should medicate this time. The surveyor review order Summary should medicate this time. The surveyor review order Summary should medicate this time. The possible of the surveyor review order Summary should medicate this time.	coording to section the receives well exected an order dated exected	F	757			
	On 06/20/24 at 09:4 survey team the that resident's	42 AM, in the presence of the S FOIA (b)(6) stated are documented in the					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		STREET ADDRESS, CIT 439 BELLEVUE AVEN TRENTON, NJ 086	NUE	<u>, </u>		
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F 757	behaviors would have progress notes and hexperienced a there should be a mo and indicated that as the berthe should a progress notes. She medications should a progress notes. On 06/20/24 at 11:24 provide the surveyor that the surveyor that the surveyor that the should an aprogress notes. On 06/20/24 at 11:24 provide the surveyor that the surveyor that the surveyor that the surveyor that the should an additional that the surveyor that the	stated that targeted to be reviewed in the ow many times a resident order 26.4b1. She stated that inthly NJ Exec Order 26.4b1 stated that it would be ogress notes. The saviors were occurring then be documented in the added that side effects from also be documented in the added that side effects from also be documented in the sobject of the saviors were occurring then be documented in the added that side effects from also be documented in the sobject of the savior or documentation drugs summaries were onthly. 39 AM, the facility could not a linformation. d, "Medication Use" dated the behavior monitoring for all thotic, antianxiety, tic medications will be many monthly. The nurse obsequent effects on the specific behaviors to be satisfied for residents on sychotic medications. The hat monthly psychotropic	F	757				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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BELLE CA	ARE NURSING AND REH	ABILITATION CENTER		TRENTON, NJ 08618			
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F 759	Continued From page	e 140	F 7	59			
F 759 SS=E	Free of Medication E CFR(s): 483.45(f)(1)	rror Rts 5 Prcnt or More	F 7	59		8/25/24	
	§483.45(f) Medication The facility must ensu						
	percent or greater; This REQUIREMENT by: Based on observation review, it was determensure that all medica without error of 5% of medication administration the surveyor observed medications to three opportunities, and thre which calculated to a error rate of 10.3%. To identified for 2 of 3 re #5), that were adminingurses that were obs	is not met as evidenced in, interview, and record ined that the facility failed to ations were administered r more. During the morning ation observation on 6/18/24, d two (2) nurses administer (3) residents. There were 29 see (3) errors were observed medication administration The deficient practices were sidents, (Resident #51 and stered medications by 2 of 2 erved. The facility was its during their last standard		Element 1: Corrective Actions The Director of Nursing/Design contacted pharmacy for medication for resident #51. The Director of Nursing contact pharmacy for corder for the for resident # 5. Element 2: Identification of at-All residents have the potential affected by this practice. Element 3: Systemic Change	nees rder of the cted e medication Risk Areas		
	following: 1. On 6/18/24 at 8:28 medication administration observed the Register preparing nine (9) medication card of NJ Exec Order 26.4b medication card of Resident #51 was enhave any to administration.	es were evidenced by the AM, during the morning ation pass, the surveyor, ared Nurse (RN #1) edications for Resident #51 xec Order 26.4b1 tablet of RN #1 stated that the Exec Order 26.4b1 tablets for apty, and that she did not are to Resident #51 for the 9 ed that she would have to		On June 18, 2024, the Directo Nursing/Designee initiated re-the licensed nurses on the polyprocedure for Medication Administration preparathe medication is the right drug dose, right route, right rate, right resident. To verify the Medication Administration Recthe most recent medication or administered in a timely mann ordered by the Physician or Preparation is unavailable to check the most recent medication or the medication is unavailable to check the medication is unavailable to check the most recent medication or the medication is unavailable to check the most recent medication is unavailable to check the most recent medication is unavailable to check the most recent medication is unavailable to check the medication is unavailable the medication is unavailable the medication is unava	education to icy and inistration to ation that g, right th time and at the cord reflects der and er as rovider. If a		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY
		315124	B. WING _				C 26/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2024
BELLE CA	DE NUDEINO AND DEU	IARII ITATION CENTER		4	39 BELLEVUE AVENUE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER		Т	RENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 759 Continued From page 141 F 759							
	Manager/Licensed PRN #1 stated that she had not worked at the could not speak to whavailable in the cart. At that time, Residen not upset that the because they received The surveyor reviewed Resident #51. A review of the Admission	tractical Nurse (UM/LPN #1). The was an agency nurse and the facility for months and			backup supply and if not available in the back up supply inventory to call the pharmacy and the Physician or Provide for an alternative. Pharmacy Consultant will conduct a monthly medication pass audits on for next 3 monthy on 5 licensed nurses. Element 4: Monitoring/ Quality Assurar The results of the monthly medication pass audit will be submitted to the Qual Assurance and Process Improvement Committee Meeting monthly for 3 months Based on the results of these audits, a decision will be made regarding the nefor continued submission and reporting	er the nce ality ths.	
	(MDS), an assessme reflected the resident mental status (BIMS) indicating that the resident the resident that the reside	shad a brief interview for out of 15, sident had an Second					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		315124	B. WING _			C 06/26 /	/2024	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		001201	2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIA	-	(X5) COMPLETION DATE	
F 759	that Resident #51 has available. On 6/18/24 at 11:41 ARN #1 who stated the UM/LPN #1 the reside available. Resident #1) On 6/19/24 at 8:30 A the state of the who acknow "Medication Administ included a procedure not available. The medication was not a administration, then a contacted. The medication should be The state of the within or must be called for fold documented in the Nursi stated that the computer system was nurses should still fold. A review of the Nursi NJ Exec Order 26.4b1, Notes regarding the administered.	AM, the surveyor interviewed at she had not yet told lent's was not stated that the facility's tration" policy had not e for medications that were stated that when a available during medication a supervisor should be further explained that the in a would then be checked, rmacy called because the e available within one hour. The medication was not able to the hour, then the physician low up orders and ursing Progress Notes. The medication administration is recently changed but that show nursing procedures. The medication administration is recently changed but that show nursing procedures. The medication administration is recently changed but that show nursing procedures. The medication administration is recently changed but that show nursing procedures. The medication administration is recently changed but that show nursing procedures. The medication administration is recently changed but that show nursing procedures. The medication administration is recently changed but that show nursing procedures. The medication administration is recently changed but that show nursing procedures.	F	759				
	who stated that she h							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION		PLETED
		315124	B. WING			1	C 26/2024
	ROVIDER OR SUPPLIER	HABILITATION CENTER		439	REET ADDRESS, CITY, STATE, ZIP CODE BELLEVUE AVENUE ENTON, NJ 08618	, 00.	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 759	on 6/20/24 at 1:21 F the stocked and the stocked were no medication performed with RN #	es on nurses or inservices for ration yet. PM, the survey team met with	F	759			
	medication administ observed RN #2 pre for Resident #5 which NJ Exec Order 2 RN #2 stated th NJ Exec Order 26	9 AM, during the morning ration pass, the surveyor, paring eight (8) medications the included three (3) tablets of 6.4b1 for a total of at she did not have the 5.4b1 in the medication cart ident # 5 that was due at 9					
	RN #2 who stated the the was "of that the ordering systelectronically with the stated that she was worked at the facility speak to when the RN #2 stated that she backup supply to secall the provider phat Risperdal would be that she would have have to call the physical worked that she would that she was "of the worker" with the worker was not show that she was "of the worker" with the stated that she was worked at the facility speak to when the worker was worked at the facility speak to when the worked at the	e provider pharmacy. RN #2 an agency nurse and had not for months, so she could not would be available. would have to check the e if we would have to check the e if was available or rmacy to see when the delivered. The RN also stated to tell UM/LPN #2 and might sician if the was not nistered for the 9 AM dose to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 06/26/2024
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		00/20/2024
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 759	Continued From pa	ge 144	F 7	59		
	The surveyor review Resident #5.	ved the medical record for				
		nission Record face sheet nt had diagnoses that included 26.4b1				
	a PO with a start da	er Summary Report revealed te of the state o				
		who stated that she had not ckup supply or called the				
	UM/LPN #2 who sta	B PM, the surveyor interviewed ated that she was unaware of ing available for Resident #5.				
	RN #2 who stated the backup supply, physician. Resident	PM, the surveyor interviewed that she had not yet checked told the or called the #5 had not received the d by the physician. (ERROR				
	stored in the facility	was provided by the tablets was not on the				
	the who acknowledge the Marketta who acknowledge the Administration who acknowledge the Marketta with	AM, the surveyor interviewed owledged that the "Medication by had not included a cations that were not				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING				C / 26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REF	HABILITATION CENTER	•	439 BEL	ADDRESS, CITY, STATE, ZIP CODE LEVUE AVENUE ON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		(X5) COMPLETION DATE
F 759	administration, then contacted. The backup supply would provider pharmacy of should be available added if the medicat available within one be called for follow uthe Nursing Progress the medication administration recently change follow nursing process. A review of the Nursing Progress the medication administration recently change follow nursing process. A review of the Nursing Process of the started at the	stated that when a available during medication a supervisor should be further explained that the at then be checked, and the alled because the medication within one hour. The stated that is not able to be thour, then the physician must p orders and documented in so Notes. The stated that inistration computer system d but that nurses should still dures. Ing Progress Notes for included no Progress Notes for included not being administered. PM, the surveyor interviewed none who stated that she had the state of	F.	759			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING			C 06/26/2024	
NAME OF PI	ROVIDER OR SUPPLIER	V.V.=-			TREET ADDRESS, CITY, STATE, ZIP CODE	06/	26/2024
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER			39 BELLEVUE AVENUE		
				Т	RENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 759	On 6/18/24 at 9:08 Al RN #2 administer Resident #5 which income administered.) Upon It cart, the surveyor obselectronically sign the Record (MAR) for Rehighlighted medication. The surveyor reviewer Resident #5. A review of the Admiss diagnoses that included A review of the Order a PO with a start date give 1 table.	M, the surveyor observed medications to cluded the MJ Exec Order 26.4b1 was not returning to the medication served the RN #2 Medication Administration sident #5 for all the ns that were due for 9 AM. And the medical record for sion Record revealed MJ Exec Order 26.4b1 Summary Report revealed of MJ Exec Order 26.4b1 et orally two times a day for	F	759	DEFICIENCY)		
	Further review of the revealed PO with an a start date of give 1 tablet orally two. A review of the ADD ADD ADD ADD ADD ADD ADD ADD ADD AD	for NJ Exec Order 26.4b1 tablet; o times a day for NJ Exec Order 26.4b1 tablet; o times a day for NJ Exec Order 26.4b1 for a total dose of NJ Exec Order 26.4b1 MAR revealed the Order 26.4b1. In addition, the					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING				C
NAME OF PI	ROVIDER OR SUPPLIER	313124	B. W(8)	STREE	T ADDRESS, CITY, STATE, ZIP CODE	06/	26/2024
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER			ELLEVUE AVENUE TON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 759	dates with an "X" until On 6/18/24 at 12:23 I UM/LPN #2 regarding was to be administere UM/LPN #2 checked Resident #5 and state changed electronic of was checking both sy verified that the dose #5 was to receive at 9 UM/LPN #2 explained NJ Exec Order 26.4b1 ar administered togethe UM/LPN #2 then revistated that the UM/LPN #2 then revistated that the with the light entered incorrectly be date of light explained with the light entered incorrectly be date of light explained with the light entered incorrectly be date of light explained with the light entered incorrectly be date of light explained with the light entered incorrectly be date of light explained with the light entered incorrectly be date of light explained with the light entered incorrectly be date of light explained with the light entered incorrectly be date of light explained with the light entered incorrectly be date of light explained with the light entered incorrectly be date of light entered inc	PM, the surveyor interviewed go the dose of that ed at 9 AM to Resident #5. the electronic records for ed that the facility had harting systems recently and views. UM/LPN #2 then of that Resident that Resident that Resident that there was a PO for ad that there was a PO for a total dose of the ewed the current MAR and corder 26.4b1 order was ecause the PO had a start should have been started on the execuse that that experience that that experience that the total dose but that experience that the total dose but that experience that the execusion of the execution o	F	759			
	A review of the previo	ous computer system MAR tration of ^{NJ Exec Order 26.4b1}					

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED			
		315124	B. WING _			C 06/26/2024		
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG			(X5) COMPLETION DATE
F 759	On 6/19/24 at 8:30 A the SPOINT who stated computer systems of were transferred to the computer systems of the dosage #5 that occurred on the system of the was continuing the error occurred. The were no medication administration administration administration performed on RN #2 medication administration policincludedVerify each the medication is the RIGHT DOSE, the RRATE, at the RIGHT CUSTOMERVerify most recent medication and the computer systems of the systems of the facility administration administration of the recent systems of the syst	together at 9 AM for a M, the surveyor interviewed that the facility had changed had been surveyed that all PO he new computer system. AM, the survey team met cknowledged that there was le of the construction of the construc	F7	759				
F 761 SS=E	CFR(s): 483.45(g)(h) §483.45(g) Labeling Drugs and biological	nd Biologicals	F7	761		8/25/24		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315124	B. WING		l	C 26/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	1 00/	20/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 761	§483.45(h)(1) In according to biologicals in locked of temperature controls, personnel to have according to be storage of controlled the Comprehensive Experience of the Comprehensive Experie	s, and include the y and cautionary expiration date when of Drugs and Biologicals ordance with State and slity must store all drugs and compartments under proper and permit only authorized cess to the keys. Cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nother drugs subject to the facility uses single unit ution systems in which the imal and a missing dose can is not met as evidenced on, interview, and review of ments, it was determined to a.) properly store stain clean and sanitary reas, and c.) properly label edications. This was served medication carts on and was previously cited st standard survey on	F 76	Element 1: Corrective Actions On July 29, 2024, the Director of Nursing/Designee will initiate re-e to the licensed nurses on the polic procedure for Medication Storage/Labeling, including but no to medication and biologicals are safely, securely, and properly, foll manufacturer s recommendation	cy and ot limited stored owing s or		
		AM, during initial tour of the observed in Resident Room		those of the supplier and that exp medications should be discarded medication cart. The director of nursing/designee conducted an audit of all medicati storage areas to ensure all medic	from the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD			, ا	С
		315124	B. WING				26/2024
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BELLE CA	ARE NURSING AND RE	HABILITATION CENTER		4:	39 BELLEVUE AVENUE		
BLLLL CA	AND INDIVIDUAL	HABILITATION CENTER		Т	RENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From particles which was occord NJ Exec Order stored unstop of a table next to On 6/18/24 at 11:45 presence of the US the First Floor nursi medication cart, and 32 unidentifiable loc shapes, and sizes. Two opened foil pace of the US opened date of the US opened and there pills in the medication on 6/18/24 at 12:25 presence of the US reviewed the side medication car	ge 150 supied by four residents, a box of 26.4b1 secured and in the open, on the room door. 6 AM, the surveyor, in the FOIA (b)(6) , reviewed ng unit's high side nursing dobserved the following: 6 See pills of various colors, 6 Ckages of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and the second with an once opened. 7 Chapter of the following in the second with an once opened. 8 Confirmed that the two foil ion solution should have been no loose on cart. 8 PM, the surveyor, in the FOIA (b)(6) 7 Floor nursing unit's high		761	were properly stored. The director of nursing/designee conducted an audit of all medication storage areas to ensure they are maintained in a clean and sanitary condition. The director of nursing/designee conducted an audit of all medication storage areas to ensure all medication storage areas to ensure all medications including but not limited to multidose medications are properly labeled. Element 2: Identification of at-Risk Area All residents have the potential to be affected by this practice. Element 3: Systemic Change On July 29, 2024, the Director of Nursing/Designee initiated re-education the licensed nurses on the following pound procedures: Medication Administration to verify that the medication is the right drug, right dose, right route, right rate, right time and the right resident; to verify that the Medicat Administration Record reflects the most recent medication order and that it was administered in a timely manner as ordered by the Physician or other Provider; if a medication is unavailable check the backup supply and if not available in the back up supply invento to call the pharmacy and the Physician other Provider for an alternative. Pharmacy Consultant will conduct a	as to licy	DAIL
	not be any loose pil	confirmed that there should ls in the medication cart. 6 AM, the surveyor, in the			monthly medication cart audit and medication pass audits for the next 3 monthy on the licensed nurses. Element 4: Monitoring/ Quality Assurar	ıce	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			1	C / 26/2024	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		43	REET ADDRESS, CITY, STATE, ZIP CODE 19 BELLEVUE AVENUE RENTON, NJ 08618	1 00	20,2027	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	should not be any me resident's room, and observed in Resident there." The should be no loose p and that medication i not have been in the discarded." Review of the facility' Storage/Labeling" po February 2019 include biologicals are stored properly, following marecommendations or medication supply is nursing personnel, pl members lawfully aut medications N.J.A.C. 8:39-29.4 Frequency of Meals/SCFR(s): 483.60(f)(1)-S483.60(f) Frequency S483.60(f)(1) Each refacility must provide a regular times compart the community or in a needs, preferences, in the second of the s	who stated that there edications stored in a that the medication a that the medication a should not be her confirmed that there ills in the medication carts, dentified as expired "should cart" and "should have been so "Medication licy with initiated date of ledmedications and an ufacturer's those of the supplier. The accessible only to licensed harmacy personnel, or staff thorized to administer Snacks at Bedtime (3) I of Meals esident must receive and the least three meals daily, at rable to normal mealtimes in accordance with resident requests, and plan of care.		761	The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Mee monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	d ting oe	8/25/24	
	hours between a sub breakfast the followin	nust be no more than 14 stantial evening meal and ng day, except when a erved at bedtime, up to 16						

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED
315124	B. WING		C 06/26/2024
		STREET ADDRESS, CITY, STATE, ZIP CODE	06/26/2024
		439 BELLEVUE AVENUE	
REHABILITATION CENTER		TRENTON, NJ 08618	
CIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
ast the following day if a resident this meal span. Itable, nourishing alternative as must be provided to residents at non-traditional times or outside al service times, consistent with a of care. MENT is not met as evidenced Vations, interviews, and review of documents, it was determined alled to serve residents a when there was more than a an of time between the dinner ealtimes. This deficient practice is 5 of 7 residents during the meeting (Resident #23, #55, 79), and was evidenced by the 15 AM, the surveyor in the US FOIA (b)(6) observed in the reach-in refrigerator in the FOIA (b)(6) stated that the facility mately seventy-five snacks in ack times a day for residents. continued that not all residents are some had physician ordered as sent up at a certain time and in the facility provided a few witches if a resident wanted. The onfirmed there was not enough resident, and not every resident	F 8	Element 1 A review was conducted on the d Resident #23 and snacks are no offered at bedtime. A review was conducted on the d Resident #55 and snacks are no offered at bedtime. A review was conducted on the d Resident #61 and snacks are no at bedtime. A review was conducted on the d Resident #74 and snacks are no at bedtime. A review was conducted on the d Resident #79 and snacks are no at bedtime. A review was conducted on the d Resident #79 and snacks are no at bedtime. The facility now provides sufficier for all residents including overnigl bed time. Element 2 All residents have the potential to affected by this practice. Element 3 The Administrator conduct in serve education with the U.S. FOIA (telephone).	iet of ow iet of w offered iet of w offered iet of w offered iet of w offered at snacks ht and at be
	REHABILITATION CENTER RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL LY OR LSC IDENTIFYING INFORMATION) page 152 the between a substantial evening ast the following day if a resident this meal span. itable, nourishing alternative as must be provided to residents at non-traditional times or outside that service times, consistent with a of care. MENT is not met as evidenced vations, interviews, and review of documents, it was determined alled to serve residents at when there was more than a than of time between the dinner realtimes. This deficient practice is 5 of 7 residents during the ill meeting (Resident #23, #55, 79), and was evidenced by the 15 AM, the surveyor in the US FOIA (b)(6)	REHABILITATION CENTER RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION) Page 152 Be between a substantial evening ast the following day if a resident this meal span. Itable, nourishing alternative sat non-traditional times or outside all service times, consistent with a of care. MENT is not met as evidenced Vations, interviews, and review of documents, it was determined ailed to serve residents a say when there was more than a say of time between the dinner ealtimes. This deficient practice of 5 of 7 residents during the ill meeting (Resident #23, #55, 79), and was evidenced by the 15 AM, the surveyor in the US FOIA (b)(6) Observed on the reach-in refrigerator in the FOIA (b)(6) stated that the facility mately seventy-five snacks in ack times a day for residents. Continued that not all residents is some had physician ordered ease nup at a certain time and an the facility provided a few wiches if a resident wanted. The confirmed there was not enough resident, and not every resident	A BUILDING 315124 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618 RY STATEMENT OF DEFICIENCIES DIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION) Page 152 Be between a substantial evening ast the following day if a resident this meal span. Itable, nourishing alternative so must be provided to residents at non-traditional times or outside ral service times, consistent with not care. MENT is not met as evidenced vations, interviews, and review of documents, it was determined ailed to serve residents a confirmed there was more than a lan of time between the dinner ealtimes. This deficient practice r 5 of 7 residents during the il meeting (Resident #23, #55, 19), and was evidenced by the District of the following the il meeting (Resident #23, #55, 19), and was evidenced by the District of the following the il meeting (Resident #23, #55, 19), and was evidenced by the District of the following the il meeting (Resident #23, #55, 19), and was evidenced by the District of the following the il meeting (Resident #23, #55, 19), and was evidenced by the District of the following the illumination of the following of the facility mately seventy-five snacks in ack times a day for residents. District of the following of the facility mately seventy-five snacks in ack times a day for residents. Consideration sharp the provided on the day for residents. District of the facility is provided a few inches if a resident wanted. The online of the facility provided a few inches if a resident wanted. The online of the facility policy and procedure for all residents have the potential to affected by this practice. Element 2 All residents have the potential to affected by this practice. Element 3 The Administrator conduct in sen education with the U.S. FOIA (file) the facility policy and procedure for the facility polic

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		315124	B. WING				26/ 2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		43	TREET ADDRESS, CITY, STATE, ZIP CODE 39 BELLEVUE AVENUE RENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 809	a Resident Council m residents (Resident # and #79). Five of the they did not receive I you must be "on the I on the I o	AM, the surveyor conducted eeting which included seven 3, #13, #23, #55, #61, #74, seven residents stated that IS snacks. They stated that IS snacks. They stated that ist" to receive HS snacks. The mealtimes provided by the adicated that breakfast was dinner was served at 4:30 in hours in between dinner. My the surveyor interviewed ensed Practical Nurse ted that the HS snacks unit before 7:00 PM, and in particular residents and and UM/LPN #1 stated that the stated that the stated that the stated that are never any snacks left at in the surveyor interviewed that HS snacks were and nurses, and there exists to sign that a resident in the surveyor interviewed stated that there was a list is that were sent to the individual to the surveyor interviewed exists that were sent to the individual to the surveyor interviewed exists that were sent to the individual to the surveyor interviewed exists that were sent to the individual to the surveyor interviewed exists that were sent to the individual to the surveyor interviewed exists that were sent to the individual to the surveyor interviewed exists that were sent to the individual to the surveyor interviewed exists the surveyor interviewed exists the surveyor interviewed exists that were sent to the individual to the surveyor interviewed exists the	F	809	resident census. The Food Service Director will initiate dietary staff in-service of the facilities policy and procedure for ensuring the provision of evening or bed time snacks be provided for the total resident censur. The Food Service Director will initiate a weekly audit by 4 weeks and monthly be months to monitor staff so compliance with the facilities policy and procedure ensuring the provision of evening or be time snacks. Element 4 The results of the weekly and will be submitted to the Quality Assurance and Process Improvement Committee Meet monthly for 4 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	es. by 3 for d ting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315124	B. WING			C 6/26/2024	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 439 BELLEVUE AVENUE TRENTON, NJ 08618		0/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 809	the US FOIA (besnacks were servevening. There were servevening. There were selected that who every provided. She further stated that who every provided. She further selected shades to the selected shades of the selected with reside physician's ordered enough snacks for stated the kircookies, crackers stated the kircookies, crackers provided the who received shades a physician's ordered on 6/20/24 at 1:2 presence of the stated the stated what was compared the facilia asked what was compared to the stated the stat	obeyond the surveyor interviewed by (6) (6) (a) (b) (b) (b) (b) (c) (c) (c) (d) (d) (d) (e) (e) (e) (e) (e) (e) (e) (e) (e) (e	F	809			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
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F 809	received one, and he regulation regarding that and breakfast. When snack was considered ounces of milk, whole the review of facility propolicy" dated revised residents are offered and continuously through the residents; 2. Snacks to nursing unit times; 3. Nursing or do to each resident; 4. So minutes of delivery to	g snacks, but not everyone was unsure about the he time in between dinner asked what a nourishing d, the stated eight sandwich, or pudding. Divided "Snack Program October 2022, includedAll snacks upon admissions ughout their stayHS (Hour ervice employees prepare, is including the use by date, a and in sufficient quantity to Dietary Service delivers ts/stations at specified esignated staff offers snack nacks are passed within 15 the unit or are properly station and offered at a later	F8	09		
F 812 SS=D	CFR(s): 483.60(i)(1)(1)(1)(1)(1)(1)(1)(2)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	y requirements. re food from sources ed satisfactory by federal, es. bod items obtained directly subject to applicable State	F 8	12		8/25/24

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		E SURVEY IPLETED
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F 812	(iii) This provision from consuming for \$483.60(i)(2) - Sto serve food in accostandards for food This REQUIREME by: Based on observed determined that the multiuse food-continuation storage as anitary manner. evidenced by the food-continuation storage as anitary manner. evidenced by the food-continuation storage as anitary manner. evidenced by the food-continuation storage as anitary manner. On 6/19/24 at 9:15 kitchen tour with the storage and observed. 1. In the walk-in from located in the entroonly two curtains stinside of the freeze as well as keep the freezer when the coalso ice accumulated. The storage acknowledge ac	rood-handling practices. does not preclude residents rods not procured by the facility. re, prepare, distribute and rdance with professional service safety. ENT is not met as evidenced ation and interview, it was re facility failed to a.) maintain fact surface cutting board in a microbial growth; and b.) and preparation areas in a This deficient practice was	F	Element 1 New multi-use food-contact sur cutting boards were ordered an New freezer curtains have been and received. STOIA (9)(6) Was re-educated on procedure regarding the disposition waste. Element 2 All residents have the potential affected by this practice. Element 3 The Food Service Director will in-service education with all kits on the policy and procedure for preparation, and serve-sanitary specifically as it relates to the service disposal of food. The food service director and/owill initiate in-service education use of cutting boards and proper maintaining air freezer curtains. The food service director and/owill initiate in-service education use of beard and head covering. The food service director will in the food service director will the	nd received. In ordered the proper sal of food to be conduct chen staff r food / safe or designee on proper erly condesignee on proper erly condesignee on proper g.	
	joined the tour, an	US FOIA (b)(6) d they observed several large ng boards on the storage rack		weekly audit by 4 weeks and i 3 months to monitor staff □s co with the policy and procedure for preparation, and serve-sanitary	monthly by mpliance or the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		315124	B. WING _			06/	26/2024
	ROVIDER OR SUPPLIER RE NURSING AND REH	ABILITATION CENTER		43	TREET ADDRESS, CITY, STATE, ZIP CODE 39 BELLEVUE AVENUE RENTON, NJ 08618		
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F 812	that were pitted and of acknowledged the curchanged. 3. Around the preparasurface, a pinkish colestated he discarded the chicken he was preparaguice must have gotte and both acknowneeded to be cleaned immediately. On 6/26/24 at 10:34 A the US FOIA (b)(6 a cknowledged these acknowledged these ack	discolored. The discolored titing boards needed to be determined to be des	F	312	specifically to ensure that all cutting boards, freezer curtains, food disposal, and beard and head covering meet compliance. Element 4 The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee monthly for 3 months. Base on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	ed	
F 835 SS=F	NJAC 8:39-17.2(g) Administration CFR(s): 483.70 §483.70 Administration		F 8	335			8/25/24
	A lacility must be adm	ninistered in a manner that					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 06/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REH	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 439 BELLEVUE AVENUE TRENTON, NJ 08618	ODE	0.0/2.0/2.02-7	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 835	efficiently to attain or practicable physical, well-being of each rethis REQUIREMEN' by: Based on observation pertinent facility document facility ensure a.) residents services to achieve the wellbeing and b.) the Performance Improve being implemented to previously cited deficient for the facility document facility and was evidenced to practice was identified and was evidenced to the facility facility and was evidenced to the facility document for all accountable for all accountable for all accountable for all account for the facility promulgated by governous proper health care set administrator adminicoordinates all activity that the highest degriprovided to the residual facility and the facility facilit	resources effectively and maintain the highest mental, and psychosocial sident. T is not met as evidenced ons, interviews, and review of aments, it was determined folially failed to ensure staff policies and procedures to were provided with care and heir highest practical air Quality Assurance and ement (QAPI) Program was to ensure sustainability with elencies. This deficient and on 2 of 2 nursing units, by the following: 641, F725, F756, F761, 882 Inistrator's job description the revealed the following: consible for planning and is citivities and departments at ject to rules and regulations ernment agencies to ensure ervices to residents. The sters, directs, and ties of the facility to assure ee of care is constantly	F8	Element 1 The Administrator Consultatin-service the U.S. FOIA (b) (6) description, roles, and respensure that policies and proventionist by 7/26/2024. Administrator will revise the schedule to monthly to bett facility policy and procedure. The Administrator, Director Medical Director will meet tupdate the facility assessmall special populations with The Administrator will condeducation US FOIA (b) ensure she is aware of how resident electronic medical provide them timely upon received them timely upon received by this practice. Element 3 The Administrator/ Designed in-service education with all management on policy and access to electronic medical specifically as it relates to the transport of the Administrator of Designed the facilities on-boarding process.	on their job consibilities to cocedures and emented. ction . e QAPI meeting ter monitor res. r of Nursing, to review and nent to include in the facility. duct in-service (6) to v to access I records and request. ntial to be ee will conduct Il nurse d procedures for al record the provision of ut the shift. ee will update		
	limited to: implement	s [name redacted] objectives		include in-service education	n of new hire		

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	' '	SURVEY PLETED
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		315124	B. WING			06	/26/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BELLE C	ARE NURSING AND REH	IARII ITATION CENTER		43	39 BELLEVUE AVENUE		
BLLLL CA	INE NONSING AND NEI	ABILITATION CENTER		Т	RENTON, NJ 08618		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 835	Continued From page	e 159	F	835			
		rected by the governing		000	and agency nursing staff within the fac	ility	
		tices within guidelines and			with specific emphasis on the protocol		
	recommends change	<u>~</u>			getting a new password when locked of		
		l operations of the facility;			of the system.	, at	
		with the safety of all nursing			The Administrator/ Designee will initiat	e	
		der to minimize the potential			in-service with the U.S. FOIA (b) (6)		
		; oversees and guides			and nurse management team on the		
		s in the development and			facilities policy and procedure for		
		policies and procedures; and			sufficient nurse staffing with specific		
	ensure that residents	and families receive the			emphasis on the facilities protocol for		
	highest level of service	ce in a caring and			emergency staffing.		
	compassionate atmo-	sphere which recognizes the			The Administrator/ Designee will initiat	е	
	individuals needs and	d rights			in-service education with the nurse		
					management team on the facilities pol	-	
		onference on 6/17/24 at			and procedure for timely follow-up and		
	10:00 AM, the survey				response to Consultant Pharmacist		
	US FOIA (b)(6)				Recommendations.		
	US FOIA (b)(6)	was, and the facility			The Administrator/ Designee will initiat	е	
		NJ Exec Order 26.4b1 , that			in-service education with the nurse		
	the US FOIA (b)(6	two			management team on the facilities pol	су	
		erself reviewed antibiotic			and procedure for investigation of	that	
		rviced staff on infection r requested a copy of their			reportable events or any investigation includes injury of unknown origin or	ınaı	
	infection control certif				allegation of abuse within the facility w	ith	
		ilications.			specific emphasis on the facilities prote		
	On 6/19/24 at 1:36 P	M, the surveyor interviewed			for conducting, summarizing, and	5001	
		she did not have a			reporting.		
		on control; but she reviewed			The Administrator /Designee will audit	and	
		the who also was not			monitor 5 medical records to check for		
	certified. The US FOIA (8) s				compliance with pharmacy consultant		
		ractical Nurse (UM/LPN #1)			recommendations.		
	had an infection cont				The Administrator /Designee will audit	4	
	stated the unit manag	gers provided the antibiotic			agency staff electronic medical records		
	stewardship informat	ion to the USFOIA (D)(6) who			access requests weekly for four weeks		
	reviewed, summarize	ed, and completed the			determine compliance.		
	monthly report, and t	he us fola (b)(6) in-serviced staff on			The Administrator/ Designee will audit		
	infection control.				reportable events and investigations in		
					any allegation of abuse, neglect, and o		
	On 6/20/24 at 12:36 I	PM, the surveyor interviewed			injury of unknown origin weekly times	our	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		315124	B. WING _	B. WING		C	
NAME OF P	ROVIDER OR SUPPLIER	313124	Jan 111110 _	STREET ADDRESS, CITY, STATE, ZIP C	•	6/26/2024	
TO WILL OF T	NOVIDEN ON GOL LEEN			439 BELLEVUE AVENUE	002		
BELLE CA	ARE NURSING AND RE	HABILITATION CENTER		TRENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 835	Continued From pag	ge 160	F 8	35			
	infection control. The completed yesterday. On 6/25/24 at 10:58 re-interviewed the no infection control cresponsible for provecontrol training. On 6/25/24 at 1:27 in presence of the survey team, asked was. The stroke years operations for the fadepartment heads to	AM, the surveyor who confirmed she had certification, and she was iding staff with infection AM, the surveyor who confirmed she had certification, and she was iding staff with infection AM, the surveyor in the FOIA (b)(6) , and the surveyor in the was iding staff what their role ted their role was to oversee cility, all departments and of ensure residents received afe, and needs were met.		(4) to determine compliance policy. The Administrator/Designed that audits from all departm completed to enhance reside monthly for 6 months. The ifacility audits will be from the annual department of health noted in the various F-tag, and S-tags documented threenclosed plan of correction Element 4 The results of the weekly all audits will be submitted to the Assurance and Process Implication Committee Meeting monthly Based on the results of the decision will be made regar for continued submission and	e will monitor lents are being dent care initial focus of le recent th survey as K-tag, E-tag, loughout the and monthly he Quality provement by for 6 months. se audits, a rding the need		
	administration observed Registered electronic signatures had administered to electronic Medicatio (eMAR). On 6/18/24 at 8:13 // borrow a password" using the login pass because she was an a problem with her login pass because she was an a problem with her login for 6/18/24 at 8:21 // RN #1 entering electronic AM (8 AM) and 9:00	7 AM, during the medication revation, the surveyor d Nurse (RN #1) entering is for the medications that she Resident #89 in the in Administration Record AM, RN #1 stated "I had to explaining that she was word for the UM/LPN #2 in agency nurse, and she had origin. AM, the surveyor observed tronic signatures for the 8:00 in AM (9 AM) medications for ints, (Resident #32, #61, #79,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		315124	B. WING _			C 06/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REI	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE	00/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	•	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 835	#1 stated that she had morning medications needed to sign the eshe administered more residents earlier becoming the residents earlier becoming the residents or had a NU chance to sign the eshe administer and medications that were well and 9 AM medications that were the residents revealed the resident signature. On 6/18/24 at 11:27 UM/LPN #2 at the notice had given RN #1 was a problem this resident. At that time, the US was at the resident. At that time, the US was at the resident resident.	sampled residents, at #1, #2, #3, #4, #5, #6). RN ad already administered the set those residents and MAR. RN #1 explained that brining medications to the ause they were a priority were either and she had not had a mark. MM, the surveyor observed at electronically sign for readministered to Resident and the six unsampled that the initials for the 8 AM and son 6/18/24 had the initials for UM/LPN #2. AM, the surveyor interviewed arse's station, who stated that it her login because there morning. In addition, UM/LPN ations should be signed for ministering them to the	F	835			

PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 835 Continued From page 162 On 6/25/24 at 1:27 PM, the surveyor in the			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER BELLE CARE NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 835 Continued From page 162 On 6/25/24 at 1:27 PM, the surveyor in the			315124	B. WING _				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 835 Continued From page 162 On 6/25/24 at 1:27 PM, the surveyor in the			HABILITATION CENTER	1	439 B	ELLEVUE AVENUE	1 00.	20,2024
On 6/25/24 at 1:27 PM, the surveyor in the	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI	PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO			(X5) COMPLETION DATE
presence of the US FOIA (b)(6) and survey team, asked the series what their role was. The stated their role was to oversee operations for the facility, all departments and departments and departments and department heads to ensure residents received the services, were safe, and needs were met. 3. During entrance conference on 6/17/24 at 10:00 AM, the surveyor asked the state of the services, were safed to ensure the state of the services were safed to ensure the state of the services of t	F 835	On 6/25/24 at 1:27 P presence of the US survey team, asked to was. The US survey team, asked to the services, were satisfied as the US FOIA (b) (cassigned to care for US FOIA (b) (cassigned to care for US Exec Order 26.4bit the US FOIA (b) (cassigned to care for US Exec Order 26.4bit the US FOIA (b) (cassigned to care for US Exec Order 26.4bit the US FOIA (b) (cassigned to care for US Exec Order 26.4bit the contained some US Exec Order 26.4bit care and care of the resident care and care of the care of th	PM, the surveyor in the FOIA (b)(6) and the seed their role was to oversee cility, all departments and ensure residents received afe, and needs were met. onference on 6/17/24 at yor asked the US FOIA (b)(6) 's staff was, and the sy relied heavily on Agency AM, the surveyor conducted on the Seed the UM/LPN #1 and ang: M/LPN #1 entered Resident as observed lying in bed. The resident if she could check and the resident gave ion. The surveyor observed U Exec Order 26.4b1 and the resident was directly as Seed the seed that the chuck had a large and the resident like she which UM/LPN at that time, and stated that that was Resident #32 should have t's sheet when performing and should not have left a	F	335			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER ARE NURSING AND REF	IABILITATION CENTER		439	EET ADDRESS, CITY, STATE, ZIP CODE BELLEVUE AVENUE ENTON, NJ 08618	1 00.	20/2027
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F 835	UM/LPN #1 stated the cared for the resident shift must have left the resident's bed because ame in that morning not made rounds yet rounds every two hours. The resident's during NJ Exec Order 2. A review of the CNA. A review of the CNA. The resident's revealed that 47, there were five as thirteen assigned resident's thirteen assigned resident with a US FOI/Lobserved the following observed the resident observed the resident observed the resident observed to be were observed with a NJ Exec Order 26.4b1 at the time and confinsurveyor observed on the time and c	ton 11:00 PM to 7:00 AM ne dirty sheet on the se the CNA (CNA #1) that I just got to the unit and had I UM/LPN #1 stated that were completed by the CNA surveyor observed the I the tour and the resident's 6.4b1 Assignment sheet for It for the resident census of signed CNAs. CNA #1 had idents to care for. M, the surveyor conducted on the Floor nursing A (b)(6) M, the surveyor I into Resident #32's room It lying in bed and was dent's NJ Exec Order 26.4b1 Was interviewed med that the I WESTOTE I that had a The STOTA was interviewed med that the I WESTOTE I the resident's sheet was sident's NJ Exec Order 26.4b1 The resident's I Exec Order 26.4b1 The resident's I had a The I STOTA was interviewed med that the I WESTOTE I that had a The I STOTA was interviewed med that the I WESTOTE I the resident's Sident's I The resident's I I The resident's	F	335			

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F 835	morning when she had checked the resident were were fine assure that the resident's protect as eleven assigned residence of protect the protect as eleven assigned residents for the over evening shift; and on residents for the over even	have made rounds that ad arrived at the unit and s to see if any residents needed to be including the resident's right ould not speak to why including the resident's resident's and to keep residents. Assignment sheet for at for the resident census of ssigned CNAs. CNA #2 had dents to care for. AM, the surveyor interviewed in the presence of the duled nursing staff in the regulation which required the residents for the eCNA to every fourteen right shift. The transfer for the required was very hard to find staff; the always meet the required M, the surveyor in the FOIA (b) (6) and he what their role ed their role was to oversee could be added to the surveyor in the residents received affe, and needs were met.	F	835				

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	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 439 BELLEVUE AVENUE TRENTON, NJ 08618	DE	1 00/2	.07.202-7	
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F 835	US FOIA (b)(6) for Resident #34, #6 until present. A review of the that recommendation acted on after surve On 6/20/24 at 9:36 // the sent to the facility the sent to the facility the sent to the facility the precommendations of the completed was receiving. The recommendations precommendations precommendations where the unit manager, but con the unit or divide complete. UM/LPN time to complete the was within one weel the unit managers upon the recommendation was switched on 6/3 recommendations.	recommendations revealed ns made in NEXEC OTHER 25.451, were yor inquiry. AM, the surveyor interviewed at that the STO reports were rough email by the stated that an the street recommendations were to be completed s. The street recommendations so within seven days of could not explain why the rovided from the street rough email by the street recommendations are within seven days of could not explain why the rovided from the street rough email by the street recommendations are within seven days of could not explain why the rovided from the street rough email by the street recommendations are within seven days of could not explain why the rovided from the street rough email by the street recommendations are within seven days of could not explain why the rovided from the street rough email by the street recommendations are recommendations.	F	335				

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F 835	important that the pharmacy recomm (ASAP) so that if to concern, it could be to company was new on a "learning curvor on a "learning curvor the survey team, asked was. The survey team, asked was. The department heads the services, were so the services, were to company to the survey team, asked was. The survey team, asked was. The department heads the services, were to consider the services of the line of the surveyor revision of the line of the surveyor revision of the line of the surveyor revision of the line of the	facility acted upon the nendations as soon as possible there was a medication safety be taking care of immediately. It the facility needed more to the new pharmacy consultant of to the facility and the staff was be. 7 PM, the surveyor in the SFOIA (b)(6) and the staff was to oversee facility, all departments and to ensure residents received safe, and needs were met. 100 PM, the surveyor requested copy of investigations for to the New Jersey Department or any investigations that to ensure resident #254. 10 PM, the surveyor requested copy of investigations for the New Jersey Department or any investigations that the staff was very many investigation for the cord for Resident #254. 10 PM was called to boom to assess the resident who order 26.4b1	F	335			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 835	the resident NJ Exercise resident's medical resident's medical resident's medical resident was sustained NJ Exercised NJ Exercised NJ Exercised Resident who was on NJ Exercised Resident Resident Resident Resident Resident Resident Resident Resident Resident, NJ Exercised Resident Resident, NJ Exercised Resident	cord revealed prior to the b1, they were on shift. The incident report a resident on SI Exec Order 26.4b1 Order 26.4b1 They were on SI Exec Order 26.4b1 Order 26.4b1 They were on SI Exec Order 26.4b1 Order 26.4b1 They were on SI Exec Order 26.4b1 They was an	F	335			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 835	and the Second a copy During initial tour on surveyor observed Rasleep. The surveyor resident and their unboth present in the roon 6/24/24 at 1:03 Persent in the roon 6/24/24 at 1:03 Persent in the facility had surveyor and population of the facility had survey the facility had surveyor and Perform the Second Persons coincluded the US FOUND COMMITTEE A review of the facility Resource Assessme indicated persons coincluded the US FOUND COMMITTEE A review of the facility Resource Assessme indicated persons coincluded the US FOUND COMMITTEE A review of the facility Resource Assessme indicated persons coincluded the US FOUND COMMITTEE A review of the facility Resource and Perform the Exercise of the US survey team, asked to the services, were said the services, were said the services, were said presence of the US Found Person Committee and the services, were said the services, were said presence of the US Found Person Committee and the services, were said presence of the US Found Person Committee and the services, were said presence of the US Found Person Committee and the services and Perform the Services and Perform the Services of the US Found Person Committee and Perform the Services of the US Services and Perform the Services of the US Found Person Committee and Perform the Services of the US Found Person Committee and Perform the Services of the US Found Person Committee and Perform the Services of the US Found Person Committee and Perform the Services of the US Found Person Committee and Perform the Services of the US Found Person Committee and Perform the Services of the US Found Person Committee and Perform the Services of the US Found Person Committee and Perform the Services of the US Found Person Committee and Perform the Services of the US Found Person Committee and Perform the Services of the US Found Person Committee and Perform the Services of the US Found Person Committee and Perform the Services of the US Found Person Committee and Perform the Services of the US Found Person Committee and Perform	of the facility's assessment. 6/17/24 at 10:29 AM, the esident #26 observed in bed or observed that both the sampled roommate were the US FOIA (b)(6) oom. M, the surveyor asked the A (b)(6) if the facility had ons, and the stroke confirmed confirmed confirmed confirmed confirmed sec Order 26.4b1. The completion Based modeling assessment of the facility surveyor in the signed by the stroke of the facility's what their role ed their role was to oversee cility, all departments and ensure residents received afe, and needs were met.	F	335			

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F 835	with the US FOIA (b) which included accur Set (MDS) assessment antibiotic stewardship on 6/24/24 at 1:03 P and Secondary and US FOIA (b) (any special population the facility had NJ Execondary from the NJ A review of the facility Resource Assessment indicated persons coincluded the US FO updated committee on or NJ Execondary and committee on the facility's population or NJ Execondary and committee on the facility's population or NJ Execondary and committee on the facility's population or NJ Execondary and committee on the facility's population or NJ Execondary and committee on the facility's population or NJ Execondary and committee on the facility's population or NJ Execondary and committee on the facility's population or NJ Execondary and committee on the facility's population or NJ Execondary and committee on the facility's population or NJ Execondary and committee on the facility special population or NJ Execondary and committee on the facility special population or NJ Execondary and committee on the facility special population or NJ Execondary and committee on the facility special population or NJ Execondary and committee on the facility special population or NJ Execondary and committee on the facility special population or NJ Execondary and committee on the facility special population or NJ Execondary and committee on the facility special population or NJ Execondary and committee on the facility special population or NJ Execondary and committee on the facility special population or NJ Execondary and committee on the facility special population or NJ Execondary and committee on the facility special population or NJ Execondary and committee on the facility special population or NJ Execondary and committee on the facility special population or NJ Execondary and committee or NJ Execondary and comm	A (b) (6) The survey team met of the Minimum Data ents; medication storage; Pharmacy (CP) reports; and oprogram. Moreover asked the if the facility had ents, and the if the facility had ents or order 26.4b1. The implementation of the implementation in the implem	F	335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 835	from the facility's last the facility was cited MDS assessments, rCP reports, antibiotic facility assessment to program. On 6/26/24 at 11:52 with the US FOIA (facility's QAPI programembers were part of facility obtained their program, the CMS 2567 statemen previous surveys. The facility that there were the last standard surrassessments, medicing reports, antibiotic stems assessment, and QA facility implemented acknowledged started at the facility present for the well as reviewed and assessment and revilast standard survey, she was aware of the	standard survey included for the following concerns: nedication storage, acting on stewardship program, o include of and the facility's QAPI AM, the survey team met to discuss the m which all three staff of the facility utilized the concerns for their QAPI tated the facility utilized the concerns from the survey team informed the expected concerns from the survey team met to discuss the method to discu	F	35			
F 838 SS=F	NJAC 8:39-9.2(a); 9. Facility Assessment CFR(s): 483.70(e)(1) §483.70(e) Facility as The facility must con-	-(3)	F	38			8/25/24

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F 838	resources are necess competently during be and emergencies. The update that assessmeleast annually. The facupdate this assessmeleast annually. The facupdate this assessment facility plans for, any substantial modification assessment. The facupdates or include: §483.70(e)(1) The facincluding, but not limit (i) Both the number of the resident capacity; (ii) The care required considering the types physical and cognitive and other pertinent fact that population; (iii) The staff competing provide the level and resident population; (iv) The physical envised	serve to determine what sary to care for its residents of day-to-day operations are facility must review and ent, as necessary, and at acility must also review and ent whenever there is, or the change that would require a on to any part of this illity assessment must cility's resident population, if residents and the facility's by the resident population of diseases, conditions, e disabilities, overall acuity, acts that are present within encies that are necessary to types of care needed for the ironment, equipment, hysical plant considerations of care for this population; and al, or religious factors that the care provided by the not limited to, activities and	F	338			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 838	(iv) All personnel, incemployees and those contract), and volunt education and/or trarelated to resident contracts, memory or other agreements services or equipmenormal operations and information with other such as systems for patient records and information with other systems approach that the facility failed facility-wide assess services and procedulation for systems and procedulation of the facility failed facility failed facility and with admission of the facility failed faci	cific rehabilitation therapies; cluding managers, staff (both e who provide services under teers, as well as their ining and any competencies are; brandums of understanding, with third parties to provide int to the facility during both and emergencies; and on technology resources, electronically managing electronically sharing er organizations. Lity-based and sk assessment, utilizing an h. T is not met as evidenced ons, interview, and review of uments, it was determined it to ensure that the ment identified the required ures necessary to protect the velfare of all residents prior to be Order 26.4b1 and	F	838	Element 1 The Administrator, Director of Nursing, and Medical Director have modified its facility assessment manual to include designated [NJEXCOTGET 26:401] and [NJEXCOTGET 26:401] Element 2 All residents have the potential to be affected by this practice. Element 3 The Administrator /Designee will conduin-service education with all department heads on the facility assessment manual The Administrator/designee will be responsible for maintaining and updating the facility assessment manual as necessary to include all resident special populations on an ongoing basis, but makes than annually.	uct nt ual.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 838	asleep. The survey resident and their upoth present in the On 6/24/24 at 1:03 US FOIA (b)(6) any special populate the facility had NJ A review of the facil Resource Assessmindicated persons concluded the US Foundated presence and Perfugdated Tassurance of the US presence of the US presence of the US presence of the US presence of the US as part of the facility on 6/26/24 at 10:36 presence of the US pre	Resident #26 observed in bed or observed that both the insampled roommate were with NJ Exec Order 26.4b1 room. PM, the surveyor asked the wift the facility had dons, and the wift the facility had dons, and the wift the facility Staffing & ent Completion Based of the completing assessment OIA (b)(6) and reviewed with the Quality formance Improvement of NJ Exec Order 26.4b1 or NJ Exec Ord	F 838	The Administrator/designee will a facility assessment manual weekl weeks and monthly for 3 months ensure that all special resident populations are identified. Element 4 The results of the weekly and mo audits will be submitted to the Qu Assurance and Process Improver Committee monthly for 1 quarter. on the results of the audits, a dec be made regarding the need for c submission and reporting.	nthly ality ment Based ision will	
	survey team that the	e facility did not have a main				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 838	were NJ Exec Order 28 curre	ge 174 for the two residents who ntly residing at the facility.	F 838		
F 842 SS=D	CFR(s): 483.20(f)(5) §483.20(f)(5) Resid (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use of except to the extent to do so. §483.70(i) Medical §483.70(i)(1) In accordessional standar must maintain medit that are- (i) Complete; (ii) Accurately docut (iii) Readily accessitive Systematically of the information contained and informat	ent-identifiable information. It release information that is It to the public. It release information that is It to an agent only in Contract under which the agent It disclose the information It the facility itself is permitted It records. It is permitted It	F 842		8/25/24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	, <u>v</u>	0/20/2024
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F 842	activities, judicial a law enforcement purposes, research medical examiners a serious threat to by and in complian §483.70(i)(3) The frecord information unauthorized use. §483.70(i)(4) Medic for— (i) The period of tin (ii) Five years from there is no requirer (iii) For a minor, 3 y legal age under States §483.70(i)(5) The rin (i) Sufficient inform (ii) A record of the rin (iii) The compreher provided; (iv) The results of a and resident review determinations con (v) Physician's, nur professional's prog (vi) Laboratory, rad services reports as This REQUIREME by: Complaint NJ #16.	c violence, health oversight and administrative proceedings, urposes, organ donation a purposes, or to coroners, funeral directors, and to avert health or safety as permitted ce with 45 CFR 164.512. acility must safeguard medical against loss, destruction, or cal records must be retained the required by State law; or the date of discharge when ment in State law; or vears after a resident reaches ate law. Inedical record must containation to identify the resident; resident's assessments; asive plan of care and services any preadmission screening of evaluations and ducted by the State; se's, and other licensed ress notes; and iology and other diagnostic required under §483.50. NT is not met as evidenced	F8	Element 1: Corrective Actions A search for the discharge sun		
	medical record, and	ion, interview, review of the d other pertinent facility determined that the facility		the medical record for Residen conducted and could not be for the resident was dischargedn	und. Since	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		315124	B. WING			06/	26/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BELLE CA	ARE NURSING AND RE	HABILITATION CENTER		43	9 BELLEVUE AVENUE		
DLLLL O	ARE NOROMO AND RE	TABLETATION GENTER		TF	RENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	failed to maintain are easily accessible mpractice was identiff medical records revand #252), and was a copy of the reportable event to of Health (NJDOH) On 6/18/24, the surcopy of the form sulwas not provided w surveyor requested A review of the inventional NJEV OTTO THE NUTS IN	n accurate, complete, and edical record. This deficient ed for 3 of 35 residents' riewed (Resident #97, #248, sevidenced by the following: 00 PM, the surveyor requested (b)(6) 10 ie investigation for the the New Jersey Department for Resident #248 reported on veyor was provided with a somitted to the NJDOH, but ith the investigation. The a copy of the investigation. 10 stigation reported to the number of the investigation in the investigation in the investigation in the investigation summary dated in the investigation summary dated in the investigation for the ed with Resident #248. 12 AM, the surveyor interviewed (b) in regarding the investigation interviews were interviews were	F	842	medical record was closed in then system, facility is unable to retroactively complete the discharge summary for Resident #252. A review of the medical record for Resident #248 was conducted on the investigation from the investigation from the investigation into the incident including not limited to receiving statements from relevant staff. A review of the medical record for Resident #97 with a focus on the medication record was conducted. The resident transferred to another facility. Element 2: Identification of at-Risk Area All residents have the potential to be affected by this practice. Element 3: Systemic Change The Director of Nurses/Designee will initiate re-education to the licensed nursing staff to complete a thorough investigation for reportable events with statements. An audit will be conducted weekly by 4 weeks and monthly by 3 months by the Director of Nurses/ Designee of all reportable events in that month. The Director of Nurses/ Designee will intiate re-education of licensed nursing staff on the importance of completing discharge summaries for all residents. An audit will be conducted weekly by 4 weeks and monthly by 3 months by the Director of Nursing/Designee of discharge summaries of residents discharge summaries of residents discharged in that month.	of but all	
	practice was identification medical records revand #252), and was and #252), and was a second revaluation of Health (NJDOH) a copy of the reportable event to of Health (NJDOH). On 6/18/24, the surcopy of the form sulwas not provided was not provided was not provided and approximately 1:00 nurse to be The nurse immediately the nurse immediately the nurse immediately the reportation of 6/19/24 at 1:25 third time to provide incident that occurred on 6/20/24 at 10:12 the US FOIA (b) investigation processobtained from staff,	ded for 3 of 35 residents' riewed (Resident #97, #248, evidenced by the following: 00 PM, the surveyor requested (b)(6) re investigation for the the New Jersey Department for Resident #248 reported on veyor was provided with a comitted to the NJDOH, but with the investigation. The a copy of the investigation. stigation reported to the investigation Summary dated on #248 or resident #248 or reported to the sitting in their wheelchair. Itely performed a responded responded and the total not include any sements. PM, the surveyor asked for a reported with Resident #248. PM, the surveyor interviewed (6) regarding the			complete the discharge summary for Resident #252. A review of the medical record for Resident #248 was conducted on the investigation from Investigation into the incident including not limited to receiving statements from relevant staff. A review of the medical record for Resident #97 with a focus on the medication record was conducted. The resident transferred to another facility. Element 2: Identification of at-Risk Area All residents have the potential to be affected by this practice. Element 3: Systemic Change The Director of Nurses/Designee will initiate re-education to the licensed nursing staff to complete a thorough investigation for reportable events with statements. An audit will be conducted weekly by 4 weeks and monthly by 3 months by the Director of Nurses/Designee of all reportable events in that month. The Director of Nurses/ Designee will intiate re-education of licensed nursing staff on the importance of completing discharge summaries for all residents. An audit will be conducted weekly by 4 weeks and monthly by 3 months by the Director of Nursing/Designee of discharge summaries for all residents. An audit will be conducted weekly by 4 weeks and monthly by 3 months by the Director of Nursing/Designee of discharge summaries of residents	of but all	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF B	20//255 05 0//25//55	315124	B. WING			06/	26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		43	TREET ADDRESS, CITY, STATE, ZIP CODE 39 BELLEVUE AVENUE RENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	the information gather what happened and prevent the incident for the fourth time the reported event. The investigation, accident witness statements, "it." On 6/25/24 at 1:28 Plant the investigation, accident witness statements, "it." On 6/25/24 at 1:28 Plant the investigation confirmed survey team had requaccessible, accurate, on 6/26/24 at 10:36 Apresence of the US investigation should hassessment of the rewitnesses and reside if needed; Summary, colors in the investigation should hassessment of the rewitnesses and reside if needed; Summary, colors in the investigation should hassessment of the rewitnesses and reside if needed; Summary, colors in the investigation should hassessment of the rewitnesses and reside if needed; Summary, colors in the investigation should hassessment of the rewitnesses and reside if needed; Summary, colors in the investigation should hassessment of the rewitnesses and reside if needed; Summary, colors in the investigation should hassessment of the rewitnesses and reside if needed; Summary, colors in the investigation should have been should have	out interventions in place to from reoccurring. M, the surveyor requested investigation for the facility stated regarding the trincident reports, and/or We have them but can't find M, the surveyor interviewed med medical records should complete, and accurate. all medical records that the rested should be easily and maintained. AM, the surveyor interviewed med medical records that the rested should be easily and maintained. AM, the surveyor interviewed med medical records that the rested should be easily and maintained. AM, the surveyor interviewed med medical records that the rested should be easily and maintained. AM, the surveyor interviewed med medical records that the rested should be easily and maintained. The survey team stated the locate the investigation for confirmed the mave included an interview of possible evaluation if needed with a survey team of possible medical records and interventions in twould not occur again	F	842	nursing staff regarding the protocol for ensuring pain medications are available for all residents as prescribed by their physician. An audit will be conducted weekly by 4 weeks and monthly by 3 months by the Director of Nursing/Designee regarding the accessibilty and dispensing of pain medication in that month. Element 4: Monitoring/ Quality Assuranthe results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee monthly for 6 months. Base on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	l e l ace	
	admission summary)	esident Face Sheet (an Resident #252 was / in [125000] with diagnoses					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 6/ 26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REF	IABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 439 BELLEVUE AVENUE TRENTON, NJ 08618		0/20/2024	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 842	resident's discharge A review of the electr revealed Resident #2 facility in On 6/19/24 at 12:09 the Medical Records resident was discharge facility maintained the years. On 6/25/24 at 10:33 for the strong a copy summary. The the resident's stay in paper medical charts record from medical On 6/25/24 at 1:28 P again from the discharge summary. confirmed medical re accessible, complete confirmed all medica team had requested accurate, and mainta On 6/26/24 at 10:14 surveyor that there w for the resident. The informed her that one facility was unable to asked why and where	ace sheet did not include the date. Fonic Admissions Record 252 was discharged from the constant of the surveyor interviewed personnel who stated after a ged from the facility, the emedical records for ten AM, the surveyor requested of Resident #252's discharge stated that at the time of the facility, the facility utilized and needed to locate the records. M, the surveyor requested a copy of Resident #252's At that time, the cords should be easily accessible, and accurate. The street of the facility accessible, sined. AM, the street informed the reas no discharge summary stated that staff ewas completed, but the locate it. The surveyor ethe resident was an experience of facility did not have	F	342			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
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F 842	On 6/26/24 10:35 of the US FOIA (b)(Resident #252 wa	AM, the strange in the presence and survey team stated stransferred to another facility, summary should have been	FE	342		
	A review of the Readmission summand admitted to the factors.	223 AM, the surveyor reviewed all record for Resident #97. Esident Face Sheet (an arry) reflected the resident was cility with diagnoses which				
	physician's order NJ Exec Order three times a day 1:00 PM; and 5:00	Medication cord (MAR) revealed a (PO) dated [Mark], for 26.401 tablet; give one tablet for [Mark] scheduled at 9:00 AM; Define Process of the ministration times revealed the				
	A review of the coindicated on administered and A review of the co	rresponding last section				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		315124	B. WING _			C 06/26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REF	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 439 BELLEVUE AVENUE TRENTON, NJ 08618)E	00.20.202
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 842	A review of the dated New Order 20 on No Execution 1 tablet by mouth every scheduled at 12:00 A 6:00 PM. A review of administration times On 7/21/23 at 12:00 A 6:00 PM. A review of administration times On 7/21/23 at 12:00 A administration times On 8/20/24 at 6:00 A administered. A review of the corresindicated on awaiting medication of awaiting medication of PM, the resident was no documentation for dose. On 6/20/24 at 9:36 A the No Stated No Stat	at this time. at 2:42 PM, that at 2:42 PM, that at continued on the correction and tree of the continued on the continued on the continued on the continued on the correction and tree of the correction and the continued on the correction of the correction of the correction of the corresponding revealed the following: AM, 6:00 AM, and 12:00 PM, ministered and to comment	F	342		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G		LETED
		315124	B. WING			C 26/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	1 00/	20/2024
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F 842	Continued From page	e 181	F 84	12		
	resident's "Individual Administra dated first dose admi and the last dose adr	ation Record" for NJ Exec Order 26.46				
	an	AM, US FOIA (b)(6) d survey team stated they e any additional declining				
	Policy" dated last rev Purpose: To ensure t	hat each resident's medical in accordance with accepted				
F 865 SS=F		closure/Good Faith Attmpt -(4)(b)(1)-(4)(f)(1)-(6)(h)(i)	F 86	65		8/25/24
	improvement (QAPI) Each LTC facility, inc a multiunit chain, mus maintain an effective, QAPI program that fo	esurance and performance program. Iuding a facility that is part of st develop, implement, and comprehensive, data-driven ocuses on indicators of the diagram of the facility				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		315124	B. WING			06/	26/2024
	ROVIDER OR SUPPLIER	ABILITATION CENTER		4:	TREET ADDRESS, CITY, STATE, ZIP CODE 39 BELLEVUE AVENUE RENTON, NJ 08618		
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F 865	demonstrate evidence program that meets the section. This may incomposed systems and reports of identification, reporting and prevention of advice documentation demonstration of performance (a) (a) Present Survey Agency no late promulgation of this resurvey Agency or Fedurus and Preventification during any other surver equest; and (a) Present evidence of its ongoing implementation and the requirements to a State surveyor or CMS upon (b) Program of A facility must design ongoing, comprehensing of care and ser facility. It must:	in documentation and the of its ongoing QAPI whe requirements of this lude but is not limited to demonstrating systematic and investigation, analysis, werse events; and instrating the development, evaluation of corrective the improvement activities; at its QAPI plan to the State er than 1 year after the egulation; at its QAPI plan to a State deral surveyor at each survey and upon request ey and to CMS upon at documentation and and QAPI program's the facility's compliance with the Survey Agency, Federal an request. In the CAPI program to be sive, and to address the full revices provided by the seall systems of care and	F	8865	DEFICIENCY)		
	management practice	98;					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER ARE NURSING AND REH	IABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 439 BELLEVUE AVENUE TRENTON, NJ 08618		0/20/2024	
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F 865	and resident choice; §483.75(b)(3) Utilize to define and measur facility goals that reflet facility operations that predictive of desired SNF or NF. §483.75(b) (4) Reflect care, and services the servi	the best available evidence re indicators of quality and ect processes of care and at have been shown to be outcomes for residents of a ct the complexities, unique at the facility provides. The and/or executive leadership or individual who assumes downward responsibility for operation consible and accountable for coing QAPI program is downward, and maintained and priorities. The program is sustained eadership and staffing; The program is adequately	F8	65			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION IG	, ,	ATE SURVEY DMPLETED
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	ROVIDER OR SUPPLIER	IABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 439 BELLEVUE AVENUE TRENTON, NJ 08618		0012012024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 865	§483.75(f)(6) Clear esafety, quality, rights §483.75(h) Disclosur A State or the Secret disclosure of the rece except in so far as so the compliance of su requirements of this s §483.75(i) Sanctions Good faith attempts the and correct quality de a basis for sanctions This REQUIREMENT by: Based on observation pertinent facility failed Quality Assurance ar Improvement (QAPI) implemented to ensu previously cited defice quantitative data was quality deficiencies a effectiveness. The fa standard survey on 1 by the following: Refer F641, F756, F3 During entrance confi AM, the surveyor requirements a confi	aluated for effectiveness; and expectations are set around, choice, and respect. The of information. The of information. The order of such committee and disclosure is related to che committee with the section. The order of such committee to identify efficiencies will not be used as an information. The order of such committee to identify efficiencies will not be used as an information of such as a committee to identify efficiencies will not be used as an information of such as a committee to identify and Performance The order of such committee to identify ind evaluate program was being an alyzed to identify ind evaluate program acility was cited during last 0/20/22, and was evidenced	F 8	Element 1 Facility has modified its QAPI reflect meeting on a monthly I Education will be provided to the QAPI program, policy, and Element 2 All residents have the potentia affected by this practice. Element 3 The Administrator/Designee verthat audits from all department completed to enhance reside inital focus of facility audits with the recent annual department survey as noted in the various K-tag, E-tag, and S-tags docuthroughout the enclosed plan correction. Element 4 The results of the various week	basis. all staff on d process. al to be will monitor nts are being nt care. The fill be from the of health is F-tag, umented of	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		315124	B. WING _	B. WING		C 6/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REF	IABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 439 BELLEVUE AVENUE TRENTON, NJ 08618	•	0/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 865	sheets. On 6/18/24 at 11:52 of from the program plan and lass sheets. On 6/19/24 at 9:00 A copy of the last three the facility's QAPI proprovided. On 6/20/24 at 12:57 with the US FOIA (b) which included accur Set (MDS) assessme acting on Consultant antibiotic stewardship On 6/24/24 at 1:03 PUS FOIA (b)(6) any special population the facility had NJ E A review of the facilit Resource Assessme indicated persons coincluded the US FOUND A review of the facility had NJ E A review of the facilit Resource Assessme indicated persons coincluded the US FOUND A review of the facility had NJ E A review of the facilit Resource Assessme indicated persons coincluded the US FOUND A review of the facility had NJ E A review of the facility had NJ E	AM, the surveyor requested by of the facility's QAPI st three quarterly sign-in M, the surveyor received a requarterly sign-in sheets for ogram, but no policy was PM, the survey team met policy was M, the surveyor asked the program. M, the surveyor asked the program. M, the surveyor asked the program. My provided "Facility Staffing & provided "Facility Staffing & provided "Facility Staffing & provided with the QAPI and program as part of pon. M, the survey team met with to discuss which included the facility's	F8	monthly audits noted throug of correction will be submitted. Quality Assurance and Proclimprovement Committee. Expressed these audits, a demade regarding the need for submission and reporting.	ed to the cess Based on the cision will be		

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315124	B. WING _				26/2024
	OVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 439 BELLEVUE AVENUE TRENTON, NJ 08618	DE	1 001	20/2027
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	Services (CMS) 2567 from the facility's last the facility was cited to MDS assessments, in CP reports, antibiotic facility assessment to program. On 6/26/24 at 11:52 A to do for a sked whe concerns for their QA stated the facility utility statement of deficient of the survey team inforwere repeated concerns for their QA stated the facility utility statement of deficient of the survey team inforwere repeated concerns for their QA stated the facility utility assessment, and QA facility implemented the facility in the	ers for Medicare & Medicaid of statement of deficiencies standard survey included for the following concerns: medication storage, acting on stewardship program, of include of the facility's QAPI AM, the survey team met o)(6) secuss the facility's QAPI see staff members were part re the facility obtained their api program, the cate the CMS 2567 cies from previous surveys. rmed the facility that there rns from the last standard of MDS assessments, of program, facility PI, and asked what the of ensure sustainability. The that even though she of the consument of t	F	365			
1	deficiencies and that completed reports. No additional informa	facility educated staff and					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 439 BELLEVUE AVENUE TRENTON, NJ 08618		0/20/2024
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F 865	responsible for plann activities and departr subject to rules and responsible for rules and responsible for rules and responsible for residual administers, directs, of the facility to assur care is constantly process. A review of the facility Nursing Services" job addition to the standard Director of Nursing, sersponsible for provide expert guidance. Indiposition and must be aspects of long term demonstrated ability departmentPerformabsence of the Administration and depart	ded the Administrator is ing and is accountable for all nents at [name redacted] egulations promulgated by so to ensure proper health lents. The Administrator and coordinates all activities are that the highest degree of evided to the residents The Administrator and coordinates all activities are that the highest degree of evided to the residents The Administrator and coordinates all activities are that the highest degree of evided to the residents The Administrator and coordinates all activities are that the highest degree of evided to the residents The Administrator and coordinates all activities are that the highest degree of evided to the residents The Administrator and coordinates all activities are that the highest degree of evided to the residents	F	365		
F 880 SS=E	nursing facility NJAC 8:39-33.1(a)(e Infection Prevention of CFR(s): 483.80(a)(1) §483.80 Infection Co The facility must estatinfection prevention a designed to provide a comfortable environn	& Control (2)(4)(e)(f) Introl	F	380		8/25/24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _				C / 26/2024
	ROVIDER OR SUPPLIER	HABILITATION CENTER		439 E	EET ADDRESS, CITY, STATE, ZIP CODE BELLEVUE AVENUE NTON, NJ 08618	1 00/	2012024
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F 880	§483.80(a) Infection program. The facility must esta and control program a minimum, the following services under the providing services under the procedures for the put are not limited to (i) A system of surver possible communication accepted national states and the procedures for the put are not limited to (i) A system of surver possible communication infections before the persons in the facility (ii) When and to who communicated disease reported; (iii) Standard and trates to be followed to precedure to the procedure of the persons in the facility (iii) When and how is resident; including the persons in the facility (iii) Standard and trates to be followed to precedure to precedure the persons in the facility (iii) Standard and trates to be followed to precedure the persons in the facility (iii) Standard and trates the persons in the facility (iii) Standard and trates to be followed to precedure the persons in the facility (iii) Standard and trates to be followed to precedure the persons in the facility (iii) Standard and trates to be followed to precedure the persons in the facility (iii) Standard and trates to be followed to precedure the persons in the facility (iii) Standard and trates to be followed to precedure the persons in the facility (iii) Standard and trates to be followed to precedure the persons in the facility (iii) Standard and trates to be followed to precedure the persons in the facility (iii) Standard and trates to be followed to precedure the persons in the facility (iii) Standard and trates to be followed to precedure the persons in the facility (iii) Standard and trates the persons in the facility (iii) Standard and trates the persons in the facility (iii) Standard and trates the persons in the facility (iii) Standard and trates the persons in the facility (iii) Standard and trates the persons in the facility (iii) Standard and trates the persons in the facility (iii) Standard and trates the persons in the facility (iii) Standard and trates the persons in the facility (iii) Standard and t	ablish an infection prevention (IPCP) that must include, at wing elements: em for preventing, identifying, and, and controlling infections liseases for all residents, tors, and other individuals ander a contractual upon the facility assessment to §483.70(e) and following andards; In standards, policies, and rogram, which must include, illiance designed to identify ble diseases or y can spread to other or y can spread to other or infections should be used for a	F	380			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 06/26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 439 BELLEVUE AVENUE TRENTON, NJ 08618	ODE	00/20/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 880	contact will transmit (vi)The hand hygien by staff involved in or \$483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must har transport linens so a infection. \$483.80(f) Annual retransport linens so a infection. Based on observation pertinent facility failed that the facility failed in spread of infection facility failed in spread of infection astaff maintained appears of the spread of infection astaff maintained appears of the spread of infection ursing units, and we following: 1. During the initial forms of the spread of infection of the spread of infection ursing units, and we following:	ts or their food, if direct the disease; and e procedures to be followed direct resident contact. Item for recording incidents facility's IPCP and the iken by the facility. Idle, store, process, and is to prevent the spread of eview. Item for recording incidents facility's IPCP and the iken by the facility. It is not met as evidenced of eview. It is not met as evidenced on, interview, review of enuments, it was determined of to: a) change served to: a manner to prevent the or 1 of 1 resident reviewed for sident #80); b.) ensure that indiards were followed during 1 of 2 nurses observed diministration; and c.) ensure propriate nail length to prevent on for 1 of 2 unit managers. See was identified on 2 of 2 was evidenced by the	F	F880 Infection Preventice Element 1: Corrective Action The Director of Nursing/Dechanged the Infection of Nursing/Dechanged the Infection of Nursing/Dechanged all medication can all carts had tissues available when providing Infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate nail lefacility policy for infection of Nursing/Designee met with regarding appropriate	ons signees resident #80. signee ints to ensure ole for use to residents #5 of US FOIA (b) (6) ength and ontrol. After the left to have at-Risk Areas intial to be	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTE		, ,	ATE SURVEY OMPLETED
		0.5101					С
		315124	B. WING _				06/26/2024
NAME OF P	ROVIDER OR SUPPLIER			STREETA	ADDRESS, CITY, STATE, ZIP CODE		
BELLE CA	ARE NURSING AND E	REHABILITATION CENTER		439 BELL	LEVUE AVENUE		
BLLLL CA	INE NONSING AND I	CHABILITATION CENTER		TRENTO	ON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	Y MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIO			ULD BE	(X5) COMPLETION DATE
F 880	Continued From p	age 190	F 8	880			
	NJ Exec Order	_			sing/Designee will initiate re-ed	ducation	
	NO EXCO CIGO). The surveyor			ne licensed nurses on Policy a		
	observed the NJ E	xec Order 26.4b1 with a piece of		I	cedure for changing the respira		
	clear tape attache	d to the dated dated.			ipment weekly.	,	
					July 29, 2024, the Director of		
	The surveyor revie	ewed the medical record for		l l	sing/Designee will initiate re-ed	ducation	
	Resident #80.				ne licensed nurses on the Police		
				I	cedure for ensuring that tissue	•	
	A review of the Ad	mission Record face sheet (an		I	lable on the medication carts a		
	admission summa	ry) reflected the resident was		utiliz	zed for administering eye drop	s for all	
	admitted to facility	with diagnoses which included		resid	dents.		
	NJ Exec Order	26.4b1		On J	July 29, 2024, the Director of		
				Nurs	sing/Designee will initiate re-ed	ducation	
				to all	ll facility staff on the Policy and	t	
				Proc	cedure for ensuring the staff m	aintain	
					ropriate nail length to prevent t	the	
					ead of infection.		
					nent 4: Monitoring/ Quality Ass		
					its regarding changing respira		
		ost recent Minimum Data Set			ipment for appropriate residen	ts will	
		ment tool dated NJ Exec Order 28,			completed by the director of		
		ent had a brief interview for		l l	sing/designee weekly by 4 wee	eks and	
	mental status (BIN	MS) score of out of 15, which			othly by 3 months with results		
	indicated a NJ Exe	C Order 26:451			mitted to the Quality Assurance		
		0004 T			cess Improvement Committee.		
		ne 2024 Treatment		I	its regarding the availability of		
		cord (TAR) included a			nedication carts for residents	wnen	
	physician's order ((PO) dated, to change .4b1 once weekly on			ninistering eye drops, will be		
		g the night shift and as needed.			pleted by the director of sing/designee weekly by 4 wee	sko and	
	vveunesday duning	g the hight shift and as needed.		l l	ithly by 3 months with results	sks allu	
	On 6/19/24 at 10.	18 AM, the surveyor observed			mitted to the Quality Assurance	e and	
		g in bed NEECONG and NEECONG		l l	cess Improvement Committee.		
	Resident #80 was	receiving NJ Exec Order 26.4b1			its regarding fingernail length (
	1.35idGilt #00 Was	The surveyor observed		l l	be completed weekly by 4 wee		
	the NJ Exec Order	26.4b1 with a piece of clear		l l	othly for 3 months with results		
	tape attached to the			I	mitted to QAPI Committee.		
		that they change my NJ Exec Order 2		I	ed on the results of these audi	its. a	
		the nurse, and the last time it		I	sion will be made regarding th		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315124	B. WING			C 06/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE FRENTON, NJ 08618	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	Licensed Practical Noften Licensed Practical Noften Licensed Practical Noften Licensed Practical Notes and Indiana. The Licensed Practical Notes and Indiana. A review of the facil Equipment Procedure and/or cannula used.	AM, the surveyor interviewed Nurse (LPN #1) regarding how was changed, and LPN #1 nanged weekly by the PN #1 confirmed the resident that was more d. PM, the surveyor interviewed (6) who confirmed changed weekly on the 11:00 by the nurse. The ded when they changed the cknowledged past seven days because it introl issue. JS FOIA (b) (6) . ity's "Cleaning Respiratory lated revised May 2022, the condition of the change is the condition of the change it introl issue. JS FOIA (b) (6) . ity's "Cleaning Respiratory lated revised May 2022, the condition of the change is the change it introl issue.	F 880	for continued submission and regand submitted to the QAPI comm	•		
	medication administration administra	tration pass, the surveyor, OIA (b)(6) preparing so resident #5 which Order 26.4b1 The stated that she did so not the medication cart to bring the NI Exec Order 26.4b1.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG	(X3	ODATE SURVEY COMPLETED
		315124	B. WING _			C 06/26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REP	HABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIF 439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE	00.20.202
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 880	removed toilet paper hanging in the bathrough toilet paper into a smapaper to dab the of the	sident's bathroom and from the roll that was from the roll the folded the final wad, and used the toilet administering administering administering from the toilet from the toilet from the final was difficult to data that she felt the toilet tissue final was not her usual that it was difficult to know the cart. The final was folded from the folded that there were boxes for the medication carts. SFOIA (b) (6) The final was folded from the facility's infection control from the facility's infection control	F	880		
	the US FOIA (b)(6					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 6/26/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		0/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	residents. The surver manicured and long in the manicured acrylic nate length and curled. The manicured acrylic nate length and curled. The manicured acrylic hat their naithem. The surveyor provided resident carno. On 6/25/24 at 1:30 P the US FOIA (b)(6), was a staffing issue, assist with resident cacknowledged admir medications was con When asked if they was nail length, both the acknowledged that the not appropriate. The long which could resunderneath as well at the facility had no U A review of the facility which required an entincluded the length os o as not to interfere clock	inistering medication to eyor observed her nails to be in length. AM, the surveyor observed hurse's station with long ils that were over an inch in the surveyor commented to ir nails were long, and the ils and replied not to look at asked the interest if they re, and the interest is stated if there the interest is stated if there the interest is stated if there is should are. The interest is stated if there is should are. The is stated if they is should are. The is stated if they is should are. The is stated if they is should are. The is should are is should are. The is should are is should are. The is should are in the is should are. The is should are in the is should are in the is should are in the is should are. The is sh	F8				
F 881 SS=F	NJAC 8:39-19.4(a)(k Antibiotic Stewardshi CFR(s): 483.80(a)(3)	p Program	F 8	81		8/25/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315124	B. WING _		0	C 6/26/2024	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 439 BELLEVUE AVENUE TRENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 881	S483.80(a) Infection program. The facility must est and control program a minimum, the following system to monitor at This REQUIREMENT by: Based on observat pertinent facility door that the facility failer facility-wide system specifically according stewardship programuse and conduct suthrough June 2024. Cited during the facil 10/20/22, and was a Refer F865 According to the U.S.	ge 194 In prevention and control Itablish an infection prevention In (IPCP) that must include, at owing elements: Intibiotic stewardship program of the use protocols and a ntibiotic use. IT is not met as evidenced It is not met as evidenced It is not met as determined			es or of re-education policy and ewardship and t-Risk Areas ial to be eiotic monthly ee. eesignee will	DATE	
	last reviewed June and Reporting Antib Nursing homes mor practices and outco order to guide pract impact of new intervito antibiotic prescrib are shared with clin awareness about the antibiotic stewardship.	11, 2020, included, "Tracking violic Use and Outcomes nitor both antibiotic use mes related to antibiotics in ice changes and track the ventions. Data on adherence bing policies and antibiotic use icians and nurses to maintain e progress being made in ip. Process measures:		Program. A monthly audit will conducted on the Antibiotic S program for 12 months to det compliance with tracking and documentation of facility antil Element 4: Monitoring/ Qualit The results of the mothly aud submitted to the Quality Assu Process Improvement Comm for 12-months. Based on the the audits, a decision will be	I be Itewardship Itermine Ibiotic use. Ity Assurance Ilits will be Irance and Ittee monthly It results of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			1	C 26/2024
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2024
				4	39 BELLEVUE AVENUE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER			FRENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 881	Continued From page	e 195	F	881			
	Perform reviews on renew antibiotic starts to clinical assessment, pand antibiotic selection facility antibiotic use producted over time, measures can assess prescribing policies and clinicians." A review of the facility policy dated reviewed [Infection Preventioning review antibiotic utilizes the wardship program situations that are not appropriate use of an antibiotic regimens we facility-approved antibiotic regimens we facility-approved antibiotic resident name and mand room number; daname of antibiotic; starting the starting transfer of the starting transfer o	esident medical records for o determine whether the prescription documentation, on were in accordance with policies and practices. When monitoring process whether antibiotic re being followed by staff I's "Antibiotic Stewardship" January 2022, included the st (IP)] or designee, will ation as part of the antibiotic and identify specific to consistent with the tibioticsAll resident ill be documented on the piotic surveillance tracking a gathered will include: edical record number; unit ate and symptoms appeared;			regarding the antibiotic use in the facili	ty.	
	and adverse events. During entrance conf	erence on 6/17/24 at 10:00					
	who the was facility's previous and the part and the part and the part and reviewed immunization and infection control in the part and	the facility's US FOIA (b)(6) the facility's US FOIA (b)(6) s, and the US FOIA (b) (c) toosition was vacant. The he US FOIA (b)(6) If the two unit managers ons, antibiotic stewardship, issues. At that time the copy of the infection control					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			06/	26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 439 BELLEVUE AVENUE TRENTON, NJ 08618	ODE	1 001	20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 881	working. On 6/18/24 at 11:42 / from the serior a cope certifications and the On 6/19/24 at 12:55 from the serior a cope certifications and the well as the antibiotic surveillance. On 6/19/24 at 1:36 P the serior who stated certification in infection control with certified. The serior control with certified. The serior control certification control certification control certification control certified. The serior control certified surveyed, summarized monthly report, and thinfection control. On 6/20/24 at 12:36 I surveyor with a copy Antibiotic Summary serior control certified surveyor with a copy Antibiotic Summary reveals of the summary reveals and three serior control certification certification control certification control certification control certification control certification certi	AM, the surveyor requested y of the infection control last date the worked. PM, the surveyor requested y of the infection control last date the worked as stewardship tracking and M, the surveyor interviewed she did not have a on control; but she reviewed the stroken who also was not tated only the who also was not tated only the stroken who also was not tated on	F	381			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
		315124	B. WING		_	C 06/26/2024
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	,	STREET ADDRESS, CITY, ST 439 BELLEVUE AVENUE TRENTON, NJ 08618	TATE, ZIP CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE
F 881	and all six had a be Resident #44 and indicated if they may be resident to had diagnostic the origin documed documented if the with on documented symptests documented symptests documented; and criteria was met. For NJEXEC OTOGE 20-401 , election with on documented symptests documented documented; and criteria was met. For NJEXEC OTOGE 20-401 , election with Residual and criteria was met. For NJEXEC OTOGE 20-401 , election with Residual and criteria was met. On 6/20/24 at 12:: the NJEXEC OTOGE 20-401 who start the NJEXEC OTOGE 20-401 who sta	ox residents received SUExce Order 25.451 clank for the diagnostic section. Resident #98 both were not net the criteria for an SUExce Order 25.451 cur residents received having documented symptoms; c test documented; none had ented; and no one had	F	881	DEFICIENCY)	
	summaries were r she had just comp stewardship revie On 6/20/24 at 12:: the US FOIA (b)(documentation for stated there	When asked why the not completed, the stated oleted May's antibiotic w yesterday. 57 PM, the surveyor informed about the missing rethe antibiotic stewardship. The was a log on the medication iotic that was being tracked.				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315124	B. WING		C 06/26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	O BE COMPLÉTION
F 881	Continued From page No additional informa		F 88	31	
F 882 SS=E	NJAC 8:39-19.1 Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to hire a designated US FOIA (b)(6) worked at least part-time and had completed		F 88	Element 1 Facility will submit an infection preventionist to the Department of H with appropriate credentials by July 2024. Element 2	26,
	and evidenced by the Refer F880; F881; an			All residents have the potential to be affected by this practice. Element 3 The Administrator Consultant will co an in-service with the US FOIA (b)(6)	nduct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NG			c
		315124	B. WING			06/	26/2024
BELLE CA	I	HABILITATION CENTER STATEMENT OF DEFICIENCIES	ID.	43	REET ADDRESS, CITY, STATE, ZIP CODE 89 BELLEVUE AVENUE RENTON, NJ 08618 PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTION ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 882	AM, the surveyor as who was facility's previous and the stated herself, ar reviewed immunizat and infection contro surveyor requested certifications as well working. On 6/18/24 at 11:42 from the state and the state of the state of the state of the state of the summarized, and condition to the summarized, and condition to the summarized, and condition. On 6/20/24 at 12:36	the facility's US FOIA (b)(6) the facility's US FOIA (b)(6) as, and the US FOIA (b)(6) as, and the US FOIA (b)(6) as, and the US FOIA (b)(6) as the US FOIA (b)(6) ad the two unit managers are acopy of the infection control as the date the US stopped AM, the surveyor requested py of the infection control as the date the US worked. PM, the surveyor requested py of the infection control as the date the US worked. PM, the surveyor interviewed as the did not have a ion control; but she reviewed in the US FOIA (b)(6) also was not certified. The US FOIA (b)(6) had an infection	F	882	requirements for facility to maintain a full-time infection preventionist with appropriate credentials at all times. Administrator will inform all department heads of this new hire who in turn will inform their department employees. Administrator/Designee will audit month for 12 months the infection preventionis credentials to ensure they are compliant and up to date with regulations. Element 4 The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meet monthly for 12 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	nly st nt e I ting	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315124	B. WING			C 26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	I		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	1 06/	20/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 882	infection control. The completed May's antiyesterday. On 6/25/24 at 10:58 Are-interviewed the no infection control coresponsible for provide control training. On 6/25/24 at 1:30 Plus FOIA (b)(6) of the	stated she had just biotic stewardship review AM, the surveyor who confirmed she had ertification, and she was ling staff with infection M, the surveyor informed the e concern with infection tated the previous	F 88	2		
F 883 SS=D	the infection preventic coordinated and over prevention specialist qualifications and job Infection Preventionis Infection Prevention Pr	rol Program" policy included on and control program is reseen by an infection (infection preventionist). The responsibilities of the st are outlined in the st Job Description	F 88	3		8/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		315124	B. WING _		0	C 6/26/2024		
	ROVIDER OR SUPPLIER ARE NURSING AND REF	IABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 439 BELLEVUE AVENUE TRENTON, NJ 08618		0/20/2024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 883	annually, unless the contraindicated or the immunized during thi (iii) The resident or the has the opportunity to (iv) The resident's medocumentation that in following: (A) That the resident was provided educat and potential side effimmunization; and (B) That the resident immunization or did rimmunization due to refusal. §483.80(d)(2) Pneummust develop policies that- (i) Before offering the immunization, each representative receiv benefits and potential immunization; (ii) Each resident is communization, unless medically contraindical ready been immunication that in the opportunity to (iv) The resident's medocumentation that in following:	of the immunization; offered an influenza or 1 through March 31 immunization is medically or resident has already been or time period; or eresident's representative or refuse immunization; and odical record includes or includes or resident's representative ion regarding the benefits of influenza or received the influenza or receive the influenza medical contraindications or occocal disease. The facility or and procedures to ensure or pneumococcal or esident or the resident's or es education regarding the offered a pneumococcal or the immunization is or eresident's representative or refuse immunization; and	F	883				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE COMP	
		315124	B. WING _			06/	26/2024
NAME OF PI	ROVIDER OR SUPPLIER		_ 	STREET ADDRESS, CITY, STATE, ZIP C	ODE	1 00/	20/2024
DELLE O	DE NUDOINO AND DEU	A DIL ITATION OF NITED		439 BELLEVUE AVENUE			
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER		TRENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 883	Continued From page was provided education and potential side effeinmunization; and (B) That the resident pneumococcal immunithe pneumococcal immunithe pneumococcal immunithe pneumococcal immocontraindication or rethis REQUIREMENT by: Based on interview, other pertinent facility determined that the fatheir policy to a.) ensureducated on the beneffects of the NJ Extendication and The decidentified for 2 of 8 residentified for 2 of 8 residenti	on regarding the benefits ects of pneumococcal either received the nization or did not receive amunization due to medical fusal. Tis not met as evidenced record review, and review of a documents, it was acility failed to implement ure all eligible residents were effits and potential side ecc Order 26.4b1 and b.) ical record the residents' of the NEXEC Order 26.4b1 efficient practice was sidents reviewed for lent #76 and Resident #87), by the following: dmission Record, Resident the facility with diagnoses ed to NJ Exec Order 26.4b1 In the facility with diagnoses ed to NJ Exec Order 26.4b1 In the facility with diagnoses ed to NJ Exec Order 26.4b1 In the facility with diagnoses ed to NJ Exec Order 26.4b1 In the facility with diagnoses ed to NJ Exec Order 26.4b1			mococcal ons ated on the NJ Exec Order 26. ated on the NJ Exec Order 26. ated on the esident med y had been he benefits of and whethe d the vaccine t who decline e necouraged he by the Pla e. f at-Risk Area ntial to be	451 fer e or ed d as an	
	a NJ Exec Order 26.4b1	of NE of out of 15, indicating A review of Section sident #87's NJ Exec Order 26.4b1 was not up to date; that		On July 31, 2024, the Direct Nursing/Designee will initiate to the licensed nurses on the procedure on obtaining cores.	ate re-educat he policy and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING_			1	C 26/2024
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	001	20/2024
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER		4	39 BELLEVUE AVENUE		
DEELE OF	are nonomo / arb ren	ADIENTATION GENTER		Т	RENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 883			F	883	declination for the influenza or pneumococcal vaccine. On July 31, 2024, The Director of Nurs Designee will initiate an audit of 5 resid charts weekly by 4 weeks to determine compliance. Element 4: Monitoring/ Quality Assurar The results of the weekly will be submit to the Quality Assurance and Process Improvement Committee Meeting monifor 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	dent	
	the US FOIA (b)(6 stated upon admission resident's NUESEC OTHER 20.45) there was no docume received, the nurse of had the resident NJ Exec OTHER STATES STATES STATES AND EXECUTION STATES AND EXECUTION STATES AND EXEC OTHER NJ EXECUTION NJ EXEC OTHER NJ EXECUTION NJ EX	AM, the surveyor interviewed) who n, the nurse reviewed the status. The stated if inted stated if interest i					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			C 06/26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND R	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 439 BELLEVUE AVENUE TRENTON, NJ 08618	ODE	33/23/2021	
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F 883	i i	_	F 8	383			
		e Admission Record, Resident to the facility with diagnoses order 26.4b1					
	reflected the residence of 15, which indicates review of Section	der 26.4b1 was not up to date;					
	revealed no NJ Ex	ent #76's NJ Exec Order 26.4b1 Record, eec Order 26.4b1 administered, as NJ Exec Order 26.4b1					
	'NJ Exec Orde	r 26.4b1 NJ Exec Order 26.4b1 om the US FOIA (b)					
	Resident #76 was on NJEXEC OTGET 2, and NJE	, revealed that offered the There was no at the resident was educated or					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	<u> </u>	(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			06/26/2024	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS 439 BELLEVUE AV		1 00/20/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	(EACH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TION E
F 883	that the resident was prior to surv On 6/24/24 at 10:02 the stated if there who stated if there stated if there are stated if the stated if the resident in the facility could. A review of the facility could in the facility could in the facility to receive pure are indicated, will within thirty days of a the pneumococcal virepresentative shall education regarding side effects of the provaccines[] provision documented in the record residents/reto refuse vaccination entries will be documented in the record residents/reto refuse vaccination entries will be documented in the record residents/reto refuse vaccination entries will be documented in the record residents/reto refuse vaccination entries will be documented in the record residents/reto refuse vaccination entries will be documented in the record residents/reto refuse vaccination entries will be documented in the record residents/reto refuse vaccination entries will be documented in the record residents/reto refuse vaccination entries will be documented in the record residents/reto refuse vaccination entries will be documented in the record residents/reto refuse vaccination entries will be documented in the record residents/reto refuse vaccination entries will be documented in the record residents/reto refuse vaccination entries will be documented in the record residents/reto refuse vaccination entries will be documented in the record residents/reto refuse vaccination entries will be documented in the record residents/reto refuse vaccination entries will be do	AM, the surveyor interviewed dupon admission, the nurse at surveyor interviewed dupon admission, the nurse offered the at the resident was offered the at the resident was order 26.4b1 on was offered the facility did the stated the resident was order 26.4b1 on was offered on admissions, not provide documentation. AM, the strong in the OIA (b)(6), and survey team was offered on admissions, not provide documentation. By's undated "Pneumococcal ded all residents will be all vaccines to aide in ia/pneumococcal infections. The residents will be assessed for an endococcal infections. The resident or legal receive information and the benefits and potential neumococcal as of such education shall be	F	883			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315124	B. WING		C 06/26/2024	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	1 00/20/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 883	Continued From pag the pneumococcal v		F 883	3		
F 921 SS=D	CFR(s): 483.90(i) §483.90(i) Other En The facility must pro sanitary, and comforesidents, staff and This REQUIREMEN by: Complaint NJ #159 162168 Based on observation other facility documentat the facility failed	vironmental Conditions vide a safe, functional, table environment for the public. T is not met as evidenced 451; 159539; 159783; on, interview, and review of entation it was determined I to maintain resident nent, and living areas in a	F 921	F921 Element 1 On 08/14/24, The Environmental Son Director initiated re-education to housekeeping and laundry staff to ecompliance with facility policy for maintaining a safe, functional, sanit	ensure	
	safe, sanitary, and he deficient practice was units (First and Secondary to the following: On 6/19/24 at 9:09 of the hallway by Residuith Nex Order 26.4(b)(1) the across the leg of the wheelchair on 6/20/24 at 10:52 on the New Order Floor while approach surveyor entered the was Nex Order was	AM, the surveyor observed in the treat cushion and down the ronto the wheels. AM, the surveyor observed in the treat resembled seat cushion and down the ronto the wheels. AM, the surveyor observed in the wheels.		comfortable environment including limited to resident wheelchairs and equipment. On 08/14/24, The Environmental Son Director initiated re-education to housekeeping and laundry staff to ecompliance with facility policy for maintaining a safe, functional, sanitic comfortable environment including limited to resident room. On 6/29/24 Resident #18 had wheelchair cleaned by the environment service staff. On 6/29/24 Resident #18 had cleaned by the environmental service staff. Element 2	but not other ervices ensure tary, but not mental	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		315124	B. WING		0.0	C 6/26/2024	
NAME OF PI	ROVIDER OR SUPPLIER	I	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	5/20/2024	
				439 BELLEVUE AVENUE			
BELLE CA	RE NURSING AND RE	HABILITATION CENTER	TRENTON, NJ 08618				
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 921	that Registered Nur Resident Room # room, RN #1 acknow , and confirmed room's condition. On 6/20/24 at 11:55 Manager/Licensed Reconfirmed the acknowledged that not be in that condition to be in tha	AM, the surveyor requested se (RN #1) walk with them to While approaching the wledged the West of the	F 92	All residents have the potential affected by this practice. Element 3 On 8/14/2024 The Administrator Environmental Service Director a review and revised the facility procedure for maintaining a saffunctional, sanitary, comfortable environment. On 8/14/2024 The Environment Director conducted staff in-serveducation of revised facility polimaintaining a safe, functional, scomfortable environment as it in wheelchair cleaning and resided The Environmental Services Diconduct a weekly audit times 4 resident wheelchairs to determic compliance with cleanliness. We compliance is determined, the frest continue to audit 5 rooms monnext six (6) months with results to the QAPI Committee. The Environmental Services Diconduct a weekly audit times 4 resident rooms to determine cowith cleanliness and odor. Whe compliance is determined, the fresident rooms to determine cowith cleanliness and odor. Whe compliance is determined, the fresident rooms to determine cowith cleanliness and odor. Whe compliance is determined, the fresident rooms to determine cowith cleanliness and odor. Whe compliance is determined, the fresident rooms to determine cowith cleanliness and odor. Whe compliance is determined, the fresident rooms to determine cowith cleanliness and odor. Whe compliance is determined, the fresident rooms to determine cowith cleanliness and odor. Whe compliance is determined, the fresident rooms to determine cowith cleanliness and odor. Whe compliance is determined, the fresident rooms to determine cowith cleanliness and odor. Whe compliance is determined to the fresident rooms to determine cowith cleanliness and odor. Whe compliance is determined to the fresident rooms to determine cowith cleanliness and odor. Whe compliance is determined to the fresident rooms to determine cowith cleanliness and odor. Whe compliance is determined to the fresident rooms to determine to the fresident	or and r conducted y policy and fe, e tal Service vice icy for sanitary, relates to ent rooms. irector will weeks of 5 ine //hen facility will withly for the s submitted irector will weeks of 5 ompliance en facility will othly for the s submitted daily audits Assurance		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		315124	B. WING		06/2	; 26/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 921	dated last reviewed M Ensure that wheelcha kept clean and in goo an area for cleaning w	& Privacy Curtains" policy March 2024, included 1. airs and [reclining chairs] are ad repair [] 4. Designate wheelchairs, [reclining commode. If necessary, use ean heavily soiled .	F 92	submission and reporting.			

New Jersey Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		
		061101	B. WING		C 06/26/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	
BELLE CA	ARE NURSING AND REF	A39 BELLE TRENTON,	VUE AVENUE NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
S 000	Initial Comments		S 000		
S 560	Code, Chapter 8:39, Long Term Care Fact submit a plan of corre completion date, for a that the plan is imple deficiencies may rest accordance with the Administrative Code, Enforcement of Licer	v Jersey Administrative Standards for Licensure of ilities. The facility must ection, including a each deficiency and ensure mented. Failure to correct ult in enforcement action in Provisions of the New Jersey Title 8, Chapter 43E, nsure Regulations.	S 560		8/25/24
	S 560 8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.				3/23/21
	by: Part A	T is not met as evidenced		S560 Element 1 In an effort to ensure additional staff is	
	documents, it was de maintain the required staff-to-resident ratio of New Jersey for 44 reviewed.	·		added to facility staffing, the facility is working proactively in hiring staff to be able to be compliant with staffing requirements. Additional staff are bei recruited utilizing the following including but not limited to generous sign on bonuses, shift differential pay, addition	ng ng ng
	following: Reference: New Jers (NJDOH) memo, dat with N.J.S.A. (New J	e was evidenced by the sey Department of Health ed 01/28/2021, "Compliance ersey Statutes Annotated) num staffing requirements for		staffing agency contracts, job postings multiple job recruiting sites and job fail. The administrator contacted a State of New Jersey approved LGBTQI+ educing certification train the trainer program for facility educator and one direct care somewher to initiate facility wide training	rs. f ation or taff

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

TITLE (X6) DATE

Electronically Signed

STATE FORM

07/24/24

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED		
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		061101	B. WING		06/26/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE			
		439 BEI	LEVUE AVENUE	:			
BELLE CA	ARE NURSING AND REH	ABILITATION CENTI	ON, NJ 08618				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
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S 560	Continued From page	<u> </u>	S 560				
2 333							
	nursing homes," indic			Element 2			
	Governor signed into			All residents have the potential to be			
		0:13-18 (the Act), which		affected by this practice.			
		staffing requirements in		Element 3			
	nursing homes. The f	- , ,		On July 25, 2024 the			
	effective on 02/01/202	21:		Administrator/Designee will initiate			
				monitoring of the nurse staff schedule	on		
		Aide (CNA) to every eight		a daily basis for compliance.			
	residents for the day	shift.		On July 25, 2024 the			
	0 1: 1 1.5			Administrator/Designee will initiate			
	One direct care staff r			in-service education to the staffing			
		ning shift, provided that no		coordinator on the requirement for sta	πing		
		staff members shall be		in the nursing home.			
		ct staff member shall be		The Administrator has designated the			
	nurse aide duties: and	a CNA and shall perform		Assistant Director of Nursing and an	o for		
	nurse aide duties, and	u		Activity aide to be the two lead trainer the LGBTQI+ staff education. Staff wi			
	One direct care staff r			trained in the LGBTQI+ program			
		t shift, provided that each		subsequent to the two lead trainers			
		ber shall sign in to work as a		received certification. Staff will be trained			
	CNA and perform CN	A duties.		on all shifts including weekends. Audi staff completion of education will be	t of		
	During entrance confe	erence on 6/17/24 at 10:00		conducted weekly by 4 weeks and mo	onthly		
	AM, the surveyor ask	ed the Licensed Nursing		by 3 months.			
	Home Administrator (LNHA) and Director of		Element 4			
	Nursing (DON) how the	ne facility's staff was, and		The results of the weekly and daily nu	rse		
	the LNHA stated that	the facility relied heavily on		staff schedule audits will be submitted	to		
	Agency staffing. At the			the Quality Assurance and Process			
	requested the Nurse	• .		Improvement Committee Meeting mo	-		
		owing weeks: 2/25/24 to		for 6 months. Based on the results of			
	3/30/24; and 6/2/24 to	6/15/24.		these audits, a decision will be made			
				regarding the need for continued			
		d the facility completed		submission and reporting.			
	Nurse Staffing Report	ts which revealed the		The administrator and HR director will			
	following:			audit employee completion of the			
	4 = 4 = 5 + 5	O-market staff		LGBTQI+ education and report month	ly to		
		Complaint staffing from		the QAPI committee.			
		e facility was deficient in					
	•	ents on 30 of 35 day shifts					
	as follows:		1				

` '		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
							С	
		061101		B. WING		06	/26/2024	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
			439 BELLE	VUE AVENUE				
BELLE CA	ARE NURSING AND REH	ABILITATION CENT	TRENTON,	NJ 08618				
(X4) ID		ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
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S 560	Continued From page	e 2		S 560				
		for 87 residents on the	day					
	shift, required at least							
		for 86 residents on the	day					
	shift, required at least	for 86 residents on the	day					
	shift, required at least		uay					
		for 86 residents on the	day					
	shift, required at least		,					
	3/1/24 had 9 CNAs for 86 residents on the day		ay					
	shift, required at least							
	3/2/24 had 5 CNAs for 86 residents on the day		ay					
	shift, required at least	t 11 CNAs.						
	3/3/24 had 6 CNAs fo	or 82 residents on the d	ay					
	shift, required at least							
		or 82 residents on the d	ay					
	shift, required at least	t 10 CNAs. or 82 residents on the d	01/					
	shift, required at least		ay					
		or 82 residents on the d	av					
	shift, required at least		~,					
	•	or 84 residents on the d	ay					
	shift, required at least	t 10 CNAs.						
		or 84 residents on the d	ay					
	shift, required at least							
		or 84 residents on the d	ay					
	shift, required at least	1 10 CNAs.						
	3/10/24 had 5 CNAs t	for 86 residents on the	day					
	shift, required at least		•					
		or 85 residents on the	day					
	shift, required at least							
		for 85 residents on the	e day					
	shift, required at least							
		for 85 residents on the	e day					
	shift, required at least	t 11 CNAs. for 85 residents on the	day					
	shift, required at least		uay					
		for 84 residents on the	day					

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		061101		B. WING			C 26/2024	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, STA	ΓΕ, ZIP CODE			
DELLE C	ADE NUDEING AND DELL	ADII ITATION CENT	439 BELLE	VUE AVENUE				
BELLE CA	ARE NURSING AND REH	ABILITATION CENT	TRENTON,	NJ 08618				
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S 560	Continued From page	÷ 3		S 560				
	shift, required at least 3/16/24 had 4 CNAs t shift, required at least	for 84 residents on the d	lay					
	shift, required at least 3/18/24 had 7 CNAs is shift, required at least 3/22/24 had 8 CNAs is shift, required at least 3/23/24 had 5 CNAs is shift, required at least 3/24/24 had 6 CNAs is	for 83 residents on the data to CNAs. for 87 residents on the data to CNAs.	lay lay					
	shift, required at least 3/26/24 had 8 CNAs the shift, required at least 3/28/24 had 7 CNAs the shift, required at least 3/29/24 had 7 CNAs the shift, required at least shift, required at least shift, required at least	for 87 residents on the day and the day an	lay lay lay					
	from 6/2/24 to 6/15/24 CNA staffing for resid as follows: 6/2/24 had 8 CNAs for shift, required at least 6/3/24 had 9 CNAs for shift, required at least 6/4/24 had 11 CNAs for shift, required at least 6/5/24 had 10 CNAs for shift, required at least	or 98 residents on the da i 12 CNAs. For 98 residents on the d i 12 CNAs. For 98 residents on the d	ent in ifts ay ay lay					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		061101		B. WING		06/2	26/2024
NAME OF P	ROVIDER OR SUPPLIER	ST	REET ADDF	RESS, CITY, STA	TE, ZIP CODE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENT		/UE AVENUE NJ 08618			
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S 560	shift, required at least 6/8/24 had 10 CNAs the shift, required at least 6/9/24 had 10 CNAs the shift, required at least 6/10/24 had 9 CNAs the shift, required at least 6/11/24 had 10 CNAs shift, required at least 6/12/24 had 9 CNAs the shift, required at least 6/13/24 had 10 CNAs shift, required at least 6/14/24 had 11 CNAs shift, required at least 6/15/24 had 8 CNAs the shift for the shi	in 12 CNAs. In 97 residents on the day In 12 CNAs. In 97 residents on the day In 12 CNAs. In 96 residents on the day In 12 CNAs. In 96 residents on the day In 12 CNAs. In 96 residents on the day In 12 CNAs. In 96 residents on the day In 12 CNAs. In 96 residents on the day In 12 CNAs. In 96 residents on the day In 12 CNAs. In 96 residents on the day In 12 CNAs. In 12 CNAs. In 12 CNAs. In 13 CNAs. In 14 CNAs. In 15 CNAs. In 16 Fesidents on the day In 16 CNAs. In 17 GNAs. In 17 GNAs. In 17 GNAs. In 18 GNAS.	y , , , y	S 560			
	the Staffing Coordina LNHA, who stated sh accordance with State one CNA to every eig shift; one CNA for eve evening shift; and one residents for the over Coordinator stated it that the facility did no ratios. Part B Based on interview at documents, it was de	tor in the presence of the e scheduled nursing staff in the regulation which required the residents for the morning ten residents for the e CNA to every fourteen night shift. The Staffing was very hard to find staff; that always meet the required that review of pertinent facilities the remained that the facility all general training for the	n d g				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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S 560	Continued From page	5		S 560				
	Queer/questioning [or identity], Intersex [per combination of male a positive) and HIV+ (H Virus [a virus that attafight infection] positive administrators and stafacility as of August 3 general training on or Individuals hired after	son is born with a and female biological trai uman Immunodeficiency acks cells that help the bo	its] / ody it a the					
	(NJDOH) memo, date Amendments Regard and HIV+ Residents of Pursuant to N.J.S.A. Imemorandum concer and HIV+ residents of N.J.S.A. 26:2G-12, 10 and a facility's respon LGBTQI+ Law. The Lon March 3, 2021 and 2021. The requirement be included in N.J.A. Specifically, the LGB specific rights and probisexual, transgender questioning, queer, and older adults and peoplong-term care facilities. The LGBTQI+ Law en HIV+ residents in facilito health care and pro	GBTQI+ Law was signed took effect on August 3 ants of the LGBTQI+ Law C. 8:39 in future rulemaking TQI+ Law establishes of tections for lesbian, gay youndesignated/non-binated intersex ("LGBTQI+) ble living with HIV ("HIV+ es ("Facilities"). Insures that LGBTQI+ and lities have equitable according the same legal one else regardless of the	RI+ ties e e tI+ ;), ed i0, v will ing. r, iry,) in d eess					

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S 560	Continued From page	9 6	S 560			
	The LGBTQI+ Law pi	rohibits facilities from taking				
	any of the following a	ctions based on a person's				
	sexual orientation, ge	ender identity, gender				
	expression, intersex s	status, or HIV status:				
	1. Denying admissio	n to a facility, transferring or				
	refusing to transfer a	resident within a facility or to				
	another facility, or dis	charging, or evicting a				
	resident from a facility					
	2. Denying a request	t by residents to share a				
	room;					
	3. Where rooms are					
	assigning or reassign	~				
		e provisions of 42 C.F.R.				
	483.10(e)(5);					
	_	ent from, or harassing a				
	resident who seeks to	•				
		other residents of the same				
	gender identity, regar					
		gender transition, has taken				
	_	s, has undergone gender				
	affirmation surgery, o					
	_	ng. For the purposes of this				
		ent includes, but is not resident to show identity				
	documents in order to					
		other persons of the same				
	gender identity;	other persons of the same				
		to use a resident's chosen				
		e the resident chooses to be				
	l •	clearly informed of the				
	resident's choice;					
		t from wearing preferred				
	clothing, accessories					
	participating in groom					
		ent's right to visit and have				
		her resident's or with visitors				
		have consensual sexual				
	relations;					
		g, or providing unequal				
		cal care, which is appropriate				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	I \ /	SURVEY PLETED
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S 5600	to the resident's bodi providing medical or similarly-situated res discomfort or unfairly dignity; and 9. Declining to provid reasonable accommon resident, subject to the 483.10(c)(6). Resident Records Additionally, facilities resident records incluidentity and the resid pronouns, as indicated. Confidentiality The LGBTQI+ Law a maintain the confider information. Unless resident's sexual orie is transgender or underesident's gender traintersex status, or a mote be disclosed. Further, facilities are steps to minimize the accidental disclosure residents, visitors, or minimum extent necesidents, visitors,	ly needs and organs, or nonmedical care that, to a ident, causes avoidable demeans the resident's de any service, care, or odation requested by the ne provisions of 42 C.F.R. are required to ensure that ude the resident's gender ent's chosen name and	a t te r er			

NAME OF PROVIDER OR SUPPLIER BELLE CARE NURSING AND REHABILITATION CENT BELLE CARE NURSING AND REHABILITATION CENT GEATH REPECTATION AND 98818 STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TENTON, NJ 98818 FROM 105 (PACH SEPTICIANO MUST BE PRECEDED BY PALL) FREITY 1/30 COMPLETE 1/30 CONSS-REFERENCE TO THE APPHOPRIATE DEFICIENCY) Fresident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility. Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling. Violations A facility or an employee of a facility that violates the requirements of the LGBTOI+ Law is subject to civil or administrative action. Training Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTOI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTOI+ and HIV+ seriors who reside in long-term care facilities in New Jersey. The required training shall address: 1. Caring for LGBTOI+ seriors and seriors living		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility. Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the residents health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling. Violations A facility or an employee of a facility that violates the requirements of the LGBTQH+ Law is subject to civil or administrative action. Training Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQH+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQH+ and HIV+ seniors who reside in long-term care facilities in New Jersey. The required training shall address:	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	LD BE COMPLETE
with HIV; 2. Preventing discrimination based on sexual orientation, gender identity or expression of	S 560	resident is partially or curtains, screens, or obarriers to providing to or fully unclothed, sha consent is required in non-therapeutic example treatment provided to a consent is required in non-therapeutic example. Facilities shall also provide to a commended by the provider, including, but the requirement of the training on employe at the facility or an employe at the facility and one direct care staff at the training within six more of the LGBTQI+ Law. Be provided by an enterpretation of the LGBTQI+ Law. Be provided by an enterpretation in identifying medical challenges far and affirming environe HIV+ seniors who restacilities in New Jerset The required training 1. Caring for LGBTQI with HIV; 2. Preventing discriments.	refully unclothed. Doors, other effective visual podily privacy, when partially all be used. Informed in relation to any mination or observation of, or o, a resident of the facility. rovide transgender residents ion-related assessments, into as having been in resident's health care ut not limited to, medical care, including it supportive counseling. If supportive counseling, we of a facility that violates the LGBTQI+ Law is subject we action. If the required training shall the tity that has demonstrated go the legal, social, and aced by, and in creating safe ments for LGBTQI+ and side in long-term care ety. In the shall address: If seniors and seniors living the legal in the second in the safter the effective date and side in long-term care ety.	S 560		

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S 560	Continued From page	e 9	S 560			
	intersex status, and H	JIV status:				
		erms commonly associated				
		n, gender identity and				
	expression, intersex					
		communicating with or				
		HIV+ seniors, including the				
		osen name and pronouns;				
	5. A description of th					
	challenges historically experienced by LGBTQI+					
	and HIV+ seniors, including discrimination when					
	seeking or receiving care at long-term care					
		nonstrated physical and				
	mental health effects	within the LGBTQ				
	community;					
	Strategies to create	e a safe and affirming				
	environment for LGB	TQI+ and HIV+ seniors,				
	including suggested of	changes to facility policies				
	and procedures, form	ns, signage, communication				
	between residents an	nd their families, activities,				
	and staff training and	in-services; and				
	_	e provisions of LGBTQI+				
	Law.	•				
	During entrance conf	erence on 6/17/24 at 10:00				
	-	ed the Licensed Nursing				
		(LNHA) and Director of				
		ovide documentation that all				
		nd trained in LGBTQ+ by an				
	approved agency.	id trafficd in LODTQ - by an				
	approved agency.					
	On 6/18/24 at 11:52 /	AM, the surveyor requested				
	staff trained and certi	for documentation of all				[
	stan trained and certi	ileu III LGD I Q+.				[
	Om 0/40/04 -+ 40:55 5	DN4 4b				
		PM, the surveyor requested				
		e third time documentation				
	for all staff trained on	LGBTQ+.				
		M, the surveyor requested				
	from the LNHA for the fourth time documentation		1			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE S	
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S 560	Continued From page	÷ 10		S 560			
	for all staff trained on	LGBTQ+.					
	Nursing (ADON) provopy of the DON's cell plus fifteen employeed training which include "Cultural Diversity/LG the course curriculum the surveyor requested ADON stated it was hall staff were trained attraining. On 6/26/24 at 10:35 Appresence of the DON acknowledged that the	AM, the Assistant Directo ided the surveyor with a rtification dated so 2024 annual mandator thirty minute training on BTQI". The ADON state was from the facility, and a copy of content. The er responsibility to ensurand certified in LGBTQ+ AM, the LNHA in the ADON, and survey team of facility had no record of trained and certified in	y d d e e				
\$1305	Sanitation (b) Responsibility for a control program shall employee who is desi control coordinator, we completed course wo control or epidemiolog provided by contract, by contract, the facility employee to impleme	the infection prevention a be assigned to an ignated as the infection ith education, training, rk, or experience in infect gy; or services shall be If the services are provid y shall designate an on-s nt, coordinate, and ensur tion control policies and	tion ded ite	\$1305			8/25/24

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
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			TRENTON,	143 00010	T			
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					DEFICIENCY)			
S1305	Continued From page	e 11		S1305				
	This REQUIREMENT is not met as evidenced							
	by:							
	Based on observation, interview, and review of				Element 1			
						tion		
	pertinent facility documentation, it was determined that the facility failed to hire a				Upon review and approval of the infec	Juon		
		•			preventionists credentials by the			
	designated Infection Preventionist (IP) who had				Department of Health, the facility hire	da		
	completed specialized training in infection control		ontrol		full-time infection preventionist on	rder 26		
	and prevention. The deficient practice was identified and evidenced by the following:				. His start date was Nu Excelor	00.720		
					Element 2			
					All residents have the potential to be			
		erence on 6/17/24 at 1			affected by this practice.			
	_	ed the Licensed Nursir	-		Element 3			
		LNHA) and Director of			As noted in element 1, facility hired a			
	Nursing (DON) who the				full-time infection preventionist. The			
		s, and the DON stated	the		Administrator informed all department			
	facility's previous IP le	eft about NJ Exec Order 26.4b1			heads of this new hire on weekless, wh	o in		
	and the p	oosition was vacant. T	he		turn will inform their department			
	DON stated herself, the	he Assistant Director of	f		employees.			
	Nursing (ADON), and	I the two unit managers	3		Administrator and HR Director will aud	dit		
	reviewed immunization	ons, antibiotic stewards	hip,		the infection preventionist credentials	and		
	and infection control i	ssues. At that time the)		continuing education upon hire and			
	surveyor requested a	copy of the infection of	ontrol		annually to ensure they are compliant	and		
	certifications as well a	as the date the IP stopp	oed		up to date with regulation.			
	working.				Element 4			
					The results of the weekly and daily au	ıdits		
	On 6/18/24 at 11:42 A	AM, the surveyor reque	sted		will be submitted to the Quality Assura			
		y of the infection contro			and Process Improvement Committee			
		last date the IP worked			Meeting monthly for 6 months. Based			
					the results of these audits, a decision			
	On 6/19/24 at 12:55 F	PM, the surveyor reque	sted		be made regarding the need for contin			
		y of the infection contro			submission and reporting.			
		last date the IP worked						
		adic a.o ii iioikoc						
	On 6/19/24 at 1:36 PM	M, the surveyor intervie	wed					
	the DON who stated s	•						
	_	on control; but she revie	wed					
		the Assistant Director o						

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Nursin DON's Practic control managinform summ and the control on 6/2 the AE NURSCOOL infectic comply yester On 6/2 re-interno inferesport control on 6/2 LNHA control day of No ad A revie Preventhe infection coordin preventhe infection of the inferesport control on the inferesport control on the inferesport control on the inferesport control day of No ad A revie Preventhe infection inferesport control i	stated only the local Nurse (UM/L) cal Nurse (UM/L) cal Nurse (UM/L) cal Nurse (UM/L) cartification. The gers provided the lation to the ADO arized, and conte ADON in-served. 20/24 at 12:36 FOON who stated contend of the ADO arized at 12:36 FOON who stated may's antification control. The lated May's antification control consible for provided training. 25/24 at 10:58 Arrivewed the ADO article for provided training. 25/24 at 1:30 Pland DON of the late of the facility and DON of the late of the facility and control control contends and control control prevention and Control control prevention and control control prevention and control control control prevention and control control prevention and control control prevention and control control prevention and control preven	also was not certified. Unit Manager/Licensed LPN) had an infection The DON stated the unit the antibiotic stewardship ON who reviewed, inpleted the monthly rep- viced staff on infection PM, the surveyor intervice If the facility had no IP is ine" was pitching in with the ADON stated she had biotic stewardship review AM, the surveyor ION who confirmed she certification, and she was ling staff with infection M, the surveyor informe the concern with infection that the previous IP's leader the previous IP's leader ION who previous IP's leader the previous IP's lea	t coort, ewed ince in just w had so dided is	\$1305			

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S1405	Continued From page 13		S1405			
S1405	5 8:39-19.5(a) Mandatory Infection Control and Sanitation		S1405			8/25/24
	a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees.					
	by: Based on interview ar documents, it was defailed to ensure that neceived a NJ Exec Or an advanced practice physician assistant wifirst day of employme This deficient practice employees reviewed #2), and was evidence On 6/24/24 at 1:39 PM	ithin two weeks prior to the nt or upon employment. was identified for 1 of 10 for new hires (Employee ed by the following: M, the surveyor reviewed the		Element 1 On 7/23/2024 The Assistant Director of Nursing/Educator initiated a review of employee files to ensure a current his and physical is on file. Employee # 2 is no longer employed of the facility. Element 2 All residents have the potential to be affected by this practice. Element 3 Administrator will in-service the human	all tory with	
	employee health files	of ten randomly selected		resource director on the policy and		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
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NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENT 439 BELLE TRENTON,	VUE AVENUE NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S1405	Continued From page	÷ 14	S1405			
	provided by the facility following: Employee #2, a regis	es since last standard survey y which revealed the tered nurse supervisor, did not include a		procedure for new hires specifically related to state regulation requirement history and physical. Administrator will audit all new employ files weekly by 2 months with results to QAPI committee. Administrator will audit all new employ files specifically regarding history and	/ee :0	
	the Human Resource confirmed that all emp	PM, the surveyor interviewed as Manager (HRM) who ployees were required to r 26.4(b)(1) completed	files specifically regarding history and physicals on a monthly basis for the next 6 months and report findings to QAPI Committee. Element 4 The results of the weekly and daily audits will be submitted to the Quality Assurance			
	On 6/26/24 at 10:35 AM, the surveyor interviewed the Assistant Director of Nursing (ADON), in the presence of Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), who acknowledged that VEX OTGET 26.4(D)(1) were to be completed prior to hire. The ADON further stated that a Registered Nurse completed an assessment upon hire and the Medical Director had 30 days to do a VEX OTGET 26.4(D)(1) The LNHA confirmed that the facility could not provide Employee #2's VEX OTGET 26.4(D)(1) prior to hire.			and Process Improvement Committee monthly for 6 months. Based on the results of these audits, a decision will made regarding the need for continue submission and reporting.	be	
	policy dated revised of Policy and Procedure all be checked for bashire, including immun employees will compl history which will be complete.	y's Evaluation/Physicals January 2024, included The [facility] personnel will seline health assessment on ization status. All new lete a screening health completed and reviewed by of the facility within 30 days				
S2120	8:39-31.1(c) Mandato	ory Physical Environment	S2120			8/25/24
	(c) Fire safety mainte	nance and retrofit of				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY	_
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPLETED	
						
		061101	B. WING		C 06/26/2024	
		001101			06/26/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
BELLE CA	ARE NURSING AND REH	IABILITATION CENT	EVUE AVENUE			
		TRENTON	I, NJ 08618			
(X4) ID		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(-/	
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPE		
				DEFICIENCY)		
S2120	Continued From page	e 15	S2120			
	•	es shall comply with the Code (N.J.A.C. 5:18) as				
	_	Jersey Department of				
		Γhe New Jersey Uniform Fire				
	Safety Code may be	obtained from the Fire				
		e Department of Community				
		, Trenton, New Jersey				
	08625-0809.					
	This DECLUDEMENT	Γ is not met as evidenced				
	by:	is not met as evidenced				
	Complaint NJ #15978	33		S2120		
				Element 1		
	Based on interview a	nd record review on 6/18/24,		The Administrator sent out a letter to t	he	
	in the presence of the			local fire official requesting the comple	etion	
	` ′	it was determined that the		of the quarterly Uniform Fire Code		
		e New Jersey Uniform Fire		inspection.		
	Safety Code inspection	ons were performed ice with N.J.A.C. 5:70. The		Element 2 All residents have the potential to be		
		I the potential to affect all		affected by this practice.		
	residents and was ev	•		Element 3		
		•		The Administrator will in-service the		
	Record review at 2:00	0 PM revealed the last NJ		director of maintenance as to the		
		uarterly inspection report		importance of following up with the loc	al	
	provided was 8.5 mor	nths ago on 9/27/23.		fire code official in a timely manner		
				regarding the uniform fire code quarte	rly	-

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
*	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		A. BUILDING: _		00	
		061101	B. WING		1	, :6/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENTI 439 BELLE TRENTON,	VUE AVENUE NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S2120	Continued From page	 ≥ 16	S2120			
	In an interview at 2:10 had difficulty scheduli officials. The Licensed Nursing	0 PM the VPE stated that he		inspection. The maintenance director inform the administrator if the local fire code official has not completed the quarterly uniform fire code inspection. Administrator will audit on a quarterly basis for 1 year to determine if the unifire code quarterly inspection has take place and will report to the QAPI committee. Element 4 The results of the weekly and daily au will be submitted to the Quality Assura and Process Improvement Committee Meeting monthly for 1 year. Based or results of these audits, a decision will made regarding the need for continue submission and reporting.	form en dits ance a the be	
S2775	8:39-39.3(a) Mandato	ory Social Work	S2775			8/25/24
	20 minutes of social v	rovide an average of at least work services per week for requires at least one ocial worker for every 120				
	by: Based on observation pertinent facility document that the facility failed to Social Worker with the available in comparison residents residing at the This deficient practice following: According to data pro	is not met as evidenced n, interviews, and review of ments, it was determined to ensure that there was a e number of required hours on to the number of the facility during the survey. E was evidenced by the ovided by the facility during on 6/17/24, the number of		Element 1 The Facility hired a full time Licensed Social Worker effective Element 2 All residents have the potential to be affected by this practice. Element 3 Administrator and Human Resources Director will audit the social worker credentials upon hire and annually to ensure compliance with regulations.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPLE	
74101 2741	or contraction	ibertii io/tiiot itembetti	A. BUILDING:			
		061101	B. WING		06/2	; 6/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENT	VUE AVENUE			
		TRENTON,	NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
S2775	Continued From page	e 17	S2775			
	residents residing at total capacity was 100 facility to provide an a social work services publich calculates to 1,	the facility was 94 and the 6. This would require the average of 20 minutes of per week for each resident		Element 4 Administrator and Human Resources Director will report audit results month for 1 year to the QAPI Committee.	lly	
	the facility's Social W she had been the SW in NEXEC O'DE 26.4bi , and facility on NEXEC O'DE 28.75 The only SW and had days of NJ Exec O	NJ Exec Order 26.4b1 at the e SW stated that she was agreed to work during the				
	with the Licensed Nui (LNHA) who stated th SW to work hours was able to work NJ s each day ar hours. The LNHA was working hours per	AM, the survey team met rsing Home Administrator nat she had hired the current per week and thought she Exec Order 26.4b1 and NJ Exec Order 26.4b1 s unaware of the SW week and stated that she with the SW regarding her				
	with the LNHA and Di The LNHA acknowled was unable to fulfill the she thought was agree that the last full time of had been other SWs before she was hired	PM, the survey team met irector of Nursing (DON). Idged that the current SW hours per week that seed upon. The LNHA added SW had resigned as of stated that she thought there that were hired but resigned as the LNHA in the intention was to hire a full stated that the SW				

New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
						<u>}</u>
		061101	B. WING		1	6/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA			
BELLE C	ARE NURSING AND REH	ARII HAHON CENT	VUE AVENUE NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
\$2775		being dispersed amongst	S2775			

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
315124 _{Y1}	B. Wing	Y2	8/30/2024	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
BELLE CARE NURSING AND RE	HABILITATION CENTER	439 BELLEVUE AVENUE		
		TRENTON, NJ 08618		
This report is completed by a qual	ified State survevor for the Medicare. Medicaid a	and/or Clinical Laboratory Improvement Amendments		

ITE	M	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix Reg. # LSC	E0004 483.73(a)	Correction Completed 08/30/2024	ID Prefix Reg. # LSC	E0006 483.73(a)(1)-(2)	Correction Completed 08/30/2024	ID Prefix Reg. # LSC	E0007 483.73(a)(3)		Correction Completed 08/30/2024
ID Prefix Reg. # LSC	E0009 483.73(a)(4)	Correction Completed 08/30/2024	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC			Correction Completed
REVIEWEI STATE AG REVIEWEI CMS RO	ENCY	REVIEWED BY (INITIALS) REVIEWED BY (INITIALS)	DATE	SIGNATURE OF	SURVEYOR			ATE	
FOLLOW U 6/26/2024	JP TO SURVEY CO	OMPLETED ON		CK FOR ANY UNCORREC ORRECTED DEFICIENCIE				YES	ы □ по

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
315124 _{Y1}	B. Wing	Y2	8/30/2024	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
BELLE CARE NURSING AND RE	HABILITATION CENTER	439 BELLEVUE AVENUE		
		TRENTON, NJ 08618		
<u> </u>	•	·		

ITE	M	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix Reg. # LSC	F0573 483.10(g)(2)(i)(ii)(Correction (3) Complete (08/30/202	red Reg. #	F0580 483.10(g)(14)(i)-(iv	Correction ()(15) Completed 08/30/2024	ID Prefix Reg. # LSC	F0600 483.12(a)(1)		Correction Completed 08/30/2024
ID Prefix Reg. # LSC	F0610 483.12(c)(2)-(4)	Correction Complete 08/30/202	red Reg. #	F0677 483.24(a)(2)	Correction Completed 08/30/2024	ID Prefix Reg. # LSC	F0697 483.25(k)		Correction Completed 08/30/2024
ID Prefix Reg. # LSC	F0725 483.35(a)(1)(2)	Correction Complete 08/30/202	red Reg. #	F0842 483.20(f)(5), 483.7 (5)	Correction 0(i)(1)- Completed 08/30/2024	ID Prefix Reg. # LSC	F0921 483.90(i)		Correction Completed 08/30/2024
ID Prefix Reg. # LSC		Correcti Complet			Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correcti			Correction	ID Prefix Reg. # LSC			Correction Completed
REVIEWE STATE AG REVIEWE CMS RO	SENCY	REVIEWED BY (INITIALS) REVIEWED BY (INITIALS)	DATE	SIGNATU	RE OF SURVEYOR			DATE	
6/26/202	JP TO SURVEY CO	OMPLETED ON			DRRECTED DEFICIENCIE IENCIES (CMS-2567) SEI			YES	в 🗆 по

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
315124 _{Y1}	B. Wing	Y2	8/30/2024	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
BELLE CARE NURSING AND REF	ABILITATION CENTER	439 BELLEVUE AVENUE		
		TRENTON, NJ 08618		

ITE	EM	DATE	ITEM		DATE	ITEM		DATE
Y4	1	Y5	Y4		Y5	Y4		Y5
ID Prefix	F0573	Correction	ID Prefix	F0580	Correction	ID Prefix	F0582	Correction
Reg.#	483.10(g)(2)(i)(ii)(3)	 Completed	Reg. #	483.10(g)(14)(i)-(iv)(15)	Completed	Reg.#	483.10(g)(17)(18)(i)-((v) Completed
LSC		08/30/2024	LSC		08/30/2024	LSC		08/30/2024
ID Prefix	F0584	Correction	ID Prefix	F0600	Correction	ID Prefix	F0607	Correction
Reg.#	483.10(i)(1)-(7)	- Completed	Reg. #	483.12(a)(1)	 Completed	Reg.#	483.12(b)(1)-(5)(ii)(iii)	Completed
LSC		08/30/2024	LSC		08/30/2024	LSC		08/30/2024
ID Prefix	F0610	Correction	ID Prefix	F0641	Correction	ID Prefix	F0656	Correction
Reg.#	483.12(c)(2)-(4)	- Completed	Reg.#	483.20(g)	Completed	Reg.#	483.21(b)(1)(3)	Completed
LSC		08/30/2024	LSC		08/30/2024	LSC		08/30/2024
ID Prefix	F0657	Correction	ID Prefix	F0658	Correction	ID Prefix	F0677	Correction
Reg.#	483.21(b)(2)(i)-(iii)	Completed	Reg.#	483.21(b)(3)(i)	Completed	Reg.#	483.24(a)(2)	Completed
LSC		08/30/2024	LSC		08/30/2024	LSC		08/30/2024
ID Prefix	F0686	Correction	ID Prefix	F0693	Correction	ID Prefix	F0697	Correction
Reg.#	483.25(b)(1)(i)(ii)	- Completed	Reg. #	483.25(g)(4)(5)	Completed	Reg.#	483.25(k)	Completed
LSC		08/30/2024	LSC		08/30/2024	LSC		08/30/2024
REVIEWE STATE AC			DATE	SIGNATURE OF	SURVEYOR	1	D	DATE
REVIEWE CMS RO	ED BY REVIEW		DATE	TITLE				DATE

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building		DATE OF REVISIT	
315124 _{Y1}	B. Wing	Y2	8/30/2024	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
BELLE CARE NURSING AND RE	HABILITATION CENTER	439 BELLEVUE AVENUE		
		TRENTON, NJ 08618		

ITE	EM	DATE	ITEM			DATE	ITEM			DATE
Y4	1	Y5	Y4			Y5	Y4			Y5
ID Prefix	F0725	Correction	ID Prefix	F0755		Correction	ID Prefix	F0756		Correction
Reg.#	483.35(a)(1)(2)	Completed	Reg. #	483.45(a)	(b)(1)-(3)	 Completed	Reg.#	483.45(c)(1)(2)(4)(5)	Completed
LSC		08/30/2024	LSC			08/30/2024 	LSC			08/30/2024
ID Prefix	F0757	Correction	ID Prefix	F0759		Correction	ID Prefix	F0761		Correction
Reg.#	483.45(d)(1)-(6)	Completed	Reg. #	483.45(f)(1)	- Completed	Reg.#	483.45(g)(h)(1)(2)		Completed
LSC		08/30/2024	LSC			08/30/2024 	LSC			08/30/2024
ID Prefix	F0809	Correction	ID Prefix	F0812		Correction	ID Prefix	F0838		Correction
Reg. #	483.60(f)(1)-(3)	Completed	Reg. #	483.60(i)(1)(2)	Completed	Reg.#	483.70(e)(1)-(3)		Completed
LSC		08/30/2024	LSC			08/30/2024	LSC			08/30/2024
ID Prefix	F0842	Correction	ID Prefix	F0865		Correction	ID Prefix	F0880		Correction
Reg.#	483.20(f)(5), 483.70(i)(1)- (5)	Completed	Reg.#	483.75(a)	(1)-(4)(b)(1)-(4)	- Completed	Reg.#	483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	(0)	- 08/30/2024 -	LSC	(1)(1)-(0)(1	1)(1)	08/30/2024 	LSC			- ' 08/30/2024 -
ID Prefix	F0881	Correction	ID Prefix	F0882		Correction	ID Prefix	F0883		Correction
Reg.#	483.80(a)(3)	Completed	Reg.#	483.80(b)	(1)-(4)	Completed	Reg.#	483.80(d)(1)(2)		Completed
LSC		08/30/2024	LSC			08/30/2024 	LSC			08/30/2024
REVIEWE STATE AC			DATE		SIGNATURE OF S	URVEYOR	<u> </u>		DATE	
REVIEWE CMS RO	ED BY REVIEW		DATE	-	TITLE				DATE	

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	R / SUPPLIER / CATION NUMBE		MULTIPLE CONS A. Building	TRUCTION					DATE OF REVIS	SIT
315124		Y1	B. Wing					Y2	8/30/2024	Y3
NAME OF	FACILITY		•			STREET ADDRESS. C	ITY, STATE, ZIP CODE			
		IG AND RF	HABILITATION C	FNTFR		439 BELLEVUE AVENU				
						TRENTON, NJ 08618				
program, corrected provision the surve	to show those and the date number and t y report form)	e deficiencie such corre the identific	es previously repo ctive action was a ation prefix code p	orted on the CMS occomplished. E previously shown	S-2567, Stater ach deficiency	ment of Deficiencies ar y should be fully identif 2567 (prefix codes sh	tory Improvement Amer nd Plan of Correction, t fied using either the reg own to the left of each	hat have b gulation or	LSC nt on	
ITE			DATE	ITEM		DATE	ITEM		DATE	
Y4			Y5	Y4		Y5	Y4		Y5	
ID Prefix	F0921		Correction							
Reg. #	483.90(i)		Completed							
LSC			- 08/30/2024							
				1						
REVIEWE	D BY	REVIEV	VED BY	DATE	SIGNATU	RE OF SURVEYOR			DATE	
STATE AG	ENCY] (INITIAI	LS)							
REVIEWE	D BY	REVIEV	VED BY	DATE	TITLE				DATE	
CMS RO		(INITIAI		-						
EOL! OW!	ID TO SUDVEY	COMPLET	ED ON	CUECK F		DDECTED DEFICIENCY	ES MAS A SLIMMADY OF	l		
6/26/202	JP TO SURVEY 1	COMPLETE	D UN			ENCIES (CMS-2567) SE	ES. WAS A SUMMARY OF NT TO THE FACILITY?		YES	NO
0,20,202	т					· · ·				

			STATE FOR	RM: REVISIT REPORT		
	R / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CONS A. Building Y1 B. Wing	STRUCTION			DATE OF REVISIT 8/30/2024
	FACILITY ARE NURSING AND F	REHABILITATION (CENTER	STREET ADDRESS, CIT 439 BELLEVUE AVENU TRENTON, NJ 08618		,
corrective	e action was accomplis tion prefix code previou	shed. Each deficien	cy should be fully ider	previously reported that have been tified using either the regulation refix codes shown to the left of e	or LSC provision nun	nber and the
ITE	И	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix	S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # LSC	8:39-5.1(a)	08/30/2024	Reg. #	Completed	Reg. #	Complete
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # LSC		Completed	Reg. #	Completed	Reg. #	Complete
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # LSC		Completed	Reg. #	Completed	Reg. #	Complete
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # LSC		Completed	Reg. #	Completed	Reg. #	Complete
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # LSC		Completed	Reg. #	Completed	Reg. #	Complete

REVIEWED BY STATE AGENCY		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURV 6/26/2024	VEY C	OMPLETED ON	_	ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF ED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	YES NO

Page 1 of 1 EVENT ID: EGES12

6/26/2024

			STA	ATE FORM: R	EVISIT REPORT					
	ER / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CONS	STRUCTION					DATE	E OF REVIS	SIT
061101	Y1	A. Building B. Wing						_{Y2} 8/30/	/2024	Y3
	FACILITY				STREET ADDRESS, CI		PCODE			
BELLE C	CARE NURSING AND RE	EHABILITATION C	ENTER		439 BELLEVUE AVENU TRENTON, NJ 08618	E				
corrective	ort is completed by a State action was accomplished to prefix code previous	ed. Each deficien	cy should be	e fully identified ι	ising either the regulation	or LSC prov	ision number a	nd the		
corrective identifica report for	e action was accomplished tion prefix code previous rm).	ed. Each deficien ly shown on the S	cy should be State Survey	e fully identified u Report (prefix co	using either the regulation odes shown to the left of	or LSC prov	ision number a	nd the	DATE	:
corrective identifica	e action was accomplishation prefix code previous rm).	ed. Each deficien	cy should be	e fully identified u Report (prefix co	ising either the regulation	or LSC proveach requirer	ision number a	nd the	DATE Y5	:
corrective identifica report for	e action was accomplishation prefix code previous rm).	ed. Each deficien ly shown on the S DATE	cy should be State Survey	e fully identified u Report (prefix co	using either the regulation odes shown to the left of DATE	or LSC prove	ision number a	nd the		
corrective identifica report for	e action was accomplishention prefix code previous rm).	ed. Each deficien ly shown on the S DATE Y5	cy should be state Survey ITEM Y4	e fully identified u Report (prefix co	using either the regulation odes shown to the left of DATE	or LSC proveach requirer	ision number a	nd the	Y5	ction

PRINTED: 11/08/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
			D MANO			R-C
		315124	B. WING _			08/30/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REF	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, 3 439 BELLEVUE AVENUE TRENTON, NJ 08618	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED		DATE
{E 000}	Initial Comments		{E 0	00}		
{F 000}	This was a revisit fo Recertification surve be in substantial con implementation of th INITIAL COMMENTS	y. The facility was found to npliance with the eir POC.	{F 0	00}		
	requirements of 42 C	substantial compliance with CFR Part 483, for Long Term encies were cited for this				
	Nursing and Rehabil	s conducted at Belle Care itation from 8/29/24 through compliance with 42 CFR erm Care facilities.				
	Immediate Jeopardy CFR 483.10 (a) (1)-F Rights (F 550, F 557 the facility failed to p (Res	finding which constituted (IJ) was identified under 42 Resident Rights/Exercise (F 561, F 603, and F 604) as rovide 1 of 1 NJ Exec Order 26.4b1 sident #1) the autonomy to activities, community dining,				
	communicate with vi will and were NJ Ex 42 CFR 483.70-Adm	gnified manner, freely sitors, and leave rooms at ec Order 26.4b1. Also, inistration who failed to plemented policies and dent Rights and Self				
	Determination as we to NJ Exec Order US FOIA (b) (6) also fa	ell as policies and procedures 26.4b1 and Street Order 25.4b1 The illed to ensure Resident #1 Admission Agreement upon				
	_	ters for Medicare and CMS) updated Guideline to				
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE		(X6) DATE

Electronically Signed 09/24/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L , IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			I	-C 30/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 439 BELLEVUE AVENUE TRENTON, NJ 08618	ODE	1 001	00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BI		(X5) COMPLETION DATE	
{F 000}	reporte Nursing Facilities must autonomy and choice practicable regarding everyday lives and rerights as nursing hom Resident #1, who had but not limited to; NUS FOIA (b)(6) #1 stated that they we participate in group a dining. Resident #1 s allowed to leave their scheduled and approved and were and were well as a limited to leave their scheduled and approved them feel which the resident which the resident state of the second at	Requirements for Providing volved individuals, revised individuals in participate in activities; room on disposable ware; relephone; and had individual individuals in a room twenty-four room; have with the made individuals in a room twenty-four room; and had individuals in a room twenty-four room; have with reported feeling in a room twenty-four room; and had individuals in a room twenty-four room; have with reported feeling in a room twenty-four room; and had individuals in a room twenty-four room; have with reported feeling in a room twenty-four room; have with reported feeling in a room twenty-four room; and had in a room twenty-four room; have with reported feeling in a room twenty-four room; and had in a room twenty-four room; have with reported feeling in a room twenty-four room; have with reported feeling in a room twenty-four room; have with reported feeling in a room twenty-four room; have with reported feeling in a room twenty-four room; have with reported feeling in a room twenty-four room; have with reported feeling in a room twenty-four room; have with reported feeling in a room twenty-four room; have with reported feeling in a room twenty-four room; have with reported feeling in a room twenty-four room; have with reported feeling in a room twenty-four room; have with reported feeling in a room twenty-four room; have with reported feeling in a room twenty-four room; have room; ha	{F 0	00}				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COI		(X3) DATE	IPLETED			
		315124	B. WING			R-C / 30/2024
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	1 00/	3372024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	The US FOIA (b)(6) ware 561, F 603, F 604, provided with the IJ to PM. An acceptable remove 8/30/24 at 1:44 PM, in facility will take to occurring or recurring corrective action plant practice including: 1) from the facility to the or the NJEWE of the ALLE to accept with additional NJEWE to accept with SPOIA (b)(6)	al plan was received on example and semplates on 8/29/24 at 4:29 al plan was received on example and the exec Order 26.4b1 from a to remediate the deficient remediate the deficient resident #1 was discharge resident #1 was di	{F 00	0}		
{F 550} SS=J	on 8/30/24, and deter 557; F 561; F 603; F removed as of 8/30/2 Resident Rights/Exer CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a rig self-determination, ar access to persons an outside the facility, in this section.	4 at 1:44 PM. cise of Rights (2)(b)(1)(2) Rights. ght to a dignified existence, and communication with and d services inside and cluding those specified in	{F 55	0}		9/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	COM	TE SURVEY MPLETED
		315124	B. WING _			R-C 8/30/2024
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 439 BELLEVUE AVENUE TRENTON, NJ 08618	•	570072027
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{F 550}	her quality of life, individuality. The promote the rights §483.10(a)(2) The access to quality severity of conditional must establish an practices regarding provision of service residents regardles §483.10(b) Exercitate The resident has rights as a resident or resident of the §483.10(b)(1) The resident can exercinterference, coerfrom the facility. §483.10(b)(2) The free of interference reprisal from the frights and to be sexercise of his or subpart. This REQUIREMED by: Based on observent pertinent facility of that the facility fail autonomy to partice community dining manner, freely community	recognizing each resident's facility must protect and sof the resident. If facility must provide equal care regardless of diagnosis, on, or payment source. A facility diagnosis and gransfer, discharge, and the resident source. See of Rights. The right to exercise his or her not of the facility and as a citizen United States. If facility must ensure that the cise his or her rights without cion, discrimination, or reprisal to resident has the right to be recording his or her rights as required under this remains the right was required under this recording his or her rights as required under this remains the resident has resident has the right to be resident has the right to be resident, and review of recording his or her rights as required under this recording his or her rights as required under this recording his or her rights as required under this recording his or her rights as required under this recording his or her rights as required under this recording his or her rights as required under this recording his or her rights as required under this recording his or her rights as required under this recording his or her rights as required his recording his or her rights as required his recording his or her rights as required his recording his recording his recording his	{F 5	1. Resident #1 was immedidischarged from the facility. Of 30th, 2024 the facility discont contracts with all NJ Exec Ord will no longer accept any villa in longer accept any villa contracts.	On August inued er 26.4b1 and lec Order 26.4b1 dents have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING				R-C /30/2024	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	30/2024	
				439	9 BELLEVUE AVENUE			
BELLE CA	ARE NURSING AND RI	EHABILITATION CENTER		TR	RENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 550}	Continued From pa	ge 4	{F 5	50}				
	Resident #1). Resident #1 was and from Resident #1 was not permitted the and community din they were not allow visitors unless scheme could not choo wear an IN Exec Order 26.4b1 par meals in their room allowed to use the which the resident day seven days a was an in the country of the coun	dmitted to the facility on the NJ Exec Order 26.4b1 pserved being to by SFOIA (b)(6) the NJ Exec Order 26.4b1 pserved being to by SFOIA (b)(6) pserved being to SFOIA (b)(6) pser			deficient practice. ¿ 3. On 8/30/2024 the Clinical VP of Operations conducted in-service education with all administrative staff of the importance of ensuring that reside are afforded the autonomy to participa group activities, communal dining, served meals in a dignified manner, freely communicate with visitors, leave room will and be free from physical restraints 4. The Administrator/designee will at 5 residents a month x 4 months to ensure they are being afforded autonomy to participate in group activities, communicate in group activities, communicate in group activities, communicate with visite leave rooms at will and be free from physical restraints. Audit findings will be shared with the QAPI committee mont x 4 months. ¿	nts te in ved s at s.¿ udit sure al		
	including with and existence; self-dete with and access to and outside the face exercise their rights NJ Exec Order resulted in an Immediately PM. The IJ began on 8/Administration was 4:29 PM. The facility Removal Plan (RR survey team verifie	ediate Jeopardy (IJ) situation. 29/24, and the facility notified of the IJ on 8/29/24 at ty submitted an acceptable on 8/30/24 at 1:44 PM. The d the implementation of the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING				-C 30/2024	
NAME OF PE	ROVIDER OR SUPPLIER	0.0.2.			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	30/2024	
	10115211 011 001 1 21211				439 BELLEVUE AVENUE			
BELLE CA	RE NURSING AND REH	ABILITATION CENTER			TRENTON, NJ 08618			
							I	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 550}	Continued From page	e 5	{F 5	50]	}			
	The findings were as	follows:						
	Reference: The Cente	ers for Medicare and						
		MS) updated Guideline to						
		I Requirements for Providing						
		volved individuals, revised						
		-21-ALL documented Skilled						
		st permit residents to have						
		to the maximum extent						
		how they wish to live their						
	rights as nursing hom	ceive care with the same						
	ngnis as nursing nom	le residents.						
	A review of the facility	r's "Resident Rights" dated						
	revised 1/3/24, includ	-						
		service designee [] will						
	inform the resident ar	nd/or the resident's						
	representative of the							
		all residents will be treated						
		age, race, ethnicity, religion,						
		ysical or mental disability,						
		s, sex, sexual orientation, or						
	, ,	oressionResident Rights: 1. ight to a dignified existence,						
		nd communication with and						
	access to persons an							
	-	. the resident has the right to						
		ct and dignity including: the						
	right to be free from p							
	restraints imposed for	r the purpose of discipline or						
	convenience [] the r							
		s [] the right to receive						
	services in the facility							
	accommodation of re							
		ght to share a room with a						
	roommate of his/her of							
	Self-determination: the and the facility must p	e resident has the right to promote and facilitate						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		315124	B. WING				-C
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		439 BI	ET ADDRESS, CITY, STATE, ZIP CODE ELLEVUE AVENUE ITON, NJ 08618	<u> </u> 087	30/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 550}	resident choice incluchoose activities, so their interests; the ri aspects of his or her resident; interact wit community; receive the time of their cho activities including s community activities confidentiality: the repersonal privacy ampersonal and medical environment: the resclean, comfortable are environment	ination through support of uding but not limited to; [] whedules [] consistent with ght to make choices about r life that are significant to the the members of the visitors of their choosing at osingparticipate in other ocial, religious, and s8. Privacy and esident has the right to d confidentiality of their al records9. Safe sident has the right to a safe, and homelike rievances: the resident has evances to the facility [] the rompt efforts by the facility to the resident may have. AM, the surveyor observed a equipment (PPE) bin outside m. At that time, the surveyor nsed Practical Nurse pervisor #1), who stated J Exec Order 26.4b1 Itaff provided care, they r) additional PPE. The aff had to wear PPE when the the room, and the LPN d that Resident #1 was a vier room unless to go to the s.4b1. The LPN Supervisor it the resident did not es; ate all their meals in their	{F 5	550}			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMP	(X3) DATE SURVEY COMPLETED		
D WING	-C		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	30/2024		
BELLE CARE NURSING AND REHABILITATION CENTER 439 BELLEVUE AVENUE TRENTON, NJ 08618			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
Continued From page 7 scheduled through the by appointment: and the resident always remained in the with stated that the nurses and Certified Nursing Aides (CNAs) were permitted in the room to provide resident care. On 8/29/24 at 9:55 AM, the surveyor observed Resident #11 ying in bed with \$\subseteq \text{SEOMA}\$ (D)(6) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '			DATE SURVEY COMPLETED
		315124	B. WING _			R-C 08/30/2024
	D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		E	0.00.202		
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	(X5) COMPLETION DATE
{F 550}	to Newcoole they wore a Newcoole they could not resident had to the room or in they could not resident saw the facil stated, "no", but they to. At the time of the integration of the was Newcoole the medical record for the medical for the medical record for the medical recor	In NJ Exec Order 26.4b1 which because it let everyone The surveyor asked if the any NJ Exec Order 26.4b1 in and the resident stated, no, The surveyor asked if the ity's and the resident thought they were supposed erview, the surveyor asked he resident reported was stated "yes", the resident AM, the surveyor reviewed r Resident #1. Sision Record face sheet (an reflected that the resident acility with diagnoses which and to; NJ Exec Order 26.4b1 The surveyor asked he resident was admitted to the facility M, accompanied by NJ S FOIA (0)(6).	{F 5	50}		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMI	(X3) DATE SURVEY COMPLETED	
D WING	-C / 30/2024	
NAME OF PROVIDER OR SUPPLIER BELLE CARE NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	3012024	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
Continued From page 9 The state of the resident had a brief interview for mental status score of out of 15, indicating that the resident had an output of 15, indicating that the resident had an output of 15, indicating that the resident had an output of 15, indicating that the resident was not permitted access to telephones, not landlines or cell phones. In the output of 15, indicated output of 15, indicated output of 15, indicated output output of 15, indicated output out		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED			
		315124	B. WING _		R-C 08/30/2024		
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION		
{F 550}	present. The Street require NJ Exec Ord were NJ Exec Ord were Street and use the NJ Exec Order 26-4b that their and use the NJ Exec Order 26-4b that their and use the NJ Exec Order 2 surveyor questioned the resident was resident was with them to NJ Exec Order 2 surveyor questioned the resident was resident was resident was with them to NJ Exec Order 2 surveyor questioned the resident was resident was resident was with them to NJ Exec Order 2 surveyor questioned the resident was resident resident who were conducted in grand staff did NJ FOI needed. The state of that the did not see [Resident further stated that the and staff were not resident requested a a NJ Exec Order and ago, and the provide, that the NJ FOI neovide, that the NJ FOI neovide neovid	were no other residents atted the resident did not because they because they stated that Resident exec Order 26.4b1 and regal was to Section was currently and the Section was currently and the stated the was working and the was working was working and had not gotten to ents yet. The surveyor asked Resident #1, and she stated was on her list. AM, the surveyor interviewed included dicrossword puzzles. The provided was activities as ed that were order 26.4b1 included dicrossword puzzles. The was ed that activity staff will that often. The was stated that activity staff will that often. The was stated the pack of playing cards about a facility was not allowed to	{F 55	50}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			R-	C 8 0/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REF			STREET ADDRESS, CITY, STATE, ZIF 439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE	00/3	50/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA	I .	(X5) COMPLETION DATE	
{F 550}	stated that [Resident that they NJ Exec Order 26.4 permitted out of their with the US FOIA (b)(6), an washcloth and towel. [Resident #1] the room with the stated that [Resident meals in their room of US FOIA (b)(6) in the room On 8/29/24 at 12:20 LPN #1 in the preser that the resident NJ Exec Order 2 was the NJ Exec Order that the resident saw a because they LPN #1 state US FOIA (b)(6) with time [Resident #1] le and doctor's appoint how often [Resident #1] had an appointments, and L unsure if there was a #1] had an appointment that the secompanied [Resident #1] had an a	where CNA (CNA #1), who #1] NJ Exec Order 26.4b1; Drder 26.4b1 and go to the #1, and the resident was room to the shower room do the CNA provided the The CNA #1 stated when it was just the resident in on the condition of the co	{F 5	50}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		315124	B. WING _		R-C 08/30/2024		
NAME OF PROVIDER OR SUPPLIER BELLE CARE NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIO		
{F 550}	Res appointment was at the surveyor then observed. Staff, use the elevator of the surveyor then observed. At that time, the surveyor then observed. At that time, the surveyor then observed. Staff, use the elevator of the surveyor then observed. Staff, use the elevator of the surveyor then observed. Staff and not need the staff of the building. The Resident #1 was transited the staff of the st	at NJ Exec Order 26.4b1 ident #1 stated their the hospital, and that their i. The surveyor asked ver received the playing card Resident #1 stated, "no". The ved Resident #1 with (6) and no residents or or to go downstairs. eyor asked Secondar 26.4b1 ported earlier that the id because they could not it was "NJESTECTION When the	{F 5	50}			
	that she had started the previous owners with the were only at the and when their mediathe were only at the state of that Resident #1 stay and went to that Resident #1 stay stated the by the stated	who stated at the facility on the facility on the facility had a contract stated that the facility for medical services, cal treatment was completed,					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONST	FRUCTION	(X3) DATE	SURVEY PLETED
		315124	B. WING			R-C 08/30/2024	
NAME OF PROVIDER OR SUPPLIER BELLE CARE NURSING AND REHABILITATION CENTER				439 BEL	ADDRESS, CITY, STATE, ZIP CODE LEVUE AVENUE ON, NJ 08618	1 00/	30/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 550}	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		{F 5	50}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _				-C 30/2024	
NAME OF PROVIDER OR SUPPLIER				STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 00/	30/2024	
					BELLEVUE AVENUE			
BELLE CA	ARE NURSING AND REH	IABILITATION CENTER			NTON, NJ 08618			
(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) COMPLETION DATE	
{F 550}	and snacks and dine resident meals will be paper goods; 3. all in served with plastic ut never permitted; 4. p the inmate resident to offered the opportuni is no food or drinks or (when clinically approximate). A review of the "Inma 8/21/23, included 1. in permitted to access to cell phones; 2. the last the inmate room prion to facilitate or partouse a telephone; 4 telephone use is permitaken care of by the lassigned COs; 5. at a participate in inmate. A review of the "Concofficers" policy dated should be treated with staff On 8/29/24 at 2:52 P signed copy that Resident Right: asked where the copsigned on admission and the stated the facility and identificing they received a Rights".	ates will receive their meals in their room; 2. all inmate e served on disposable mate resident meals will be ensils; metal utensils are rior to delivery of meal tray to be CO in attendance will be try to check the tray7. there there than a water pitcher oved) be stored at bedside Ate Phone Use" policy dated nmates are not routinely elephones, not landlines or admission; 3. the staff is ticipate in allowing inmates in rare circumstances when mitted this will be entirely in time is [facility] staff to be phone use. The cerns with Correctional 19/12/23, included that COs in dignity and respect by all mitted the server of the dignity and respect by all the server of the serv	{F 5	50}				
	asked where the cop signed on admission and the stated the facility and identif sign they received a	y was that Resident #1 and why it was just signed, that the strong Nuls x core (2034) at fied residents who did not copy of their "Resident						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING_			R-C		
NAME OF PROVIDER OR SUPPLIER			B. WING	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	08/	30/2024	
					ELLEVUE AVENUE			
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER			ITON, NJ 08618			
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 550}	Agreement" dated were admitted to the survey team that she have the surveyor with a copy Agreement" dated after Resident #1 was An acceptable Removated action plan to remedia including the resident were inserviced memo regarding were inserviced memo regarding responsible for the impolicies and regulatio The survey team verification of the survey team verification.	of Resident #1's "Admission and noted as resident discharged "Jessed Order 25". At that viewed with the stock of the nistory which revealed that the facility in viewed of the facility in viewed with the sistory which revealed that the facility in viewed of the sistory which revealed that the facility in viewed viewed with the sistory which revealed that the facility with each sistory with each with each with the had spoken to the view facility who was permitted and when. My the viewed viewed provided the of Resident #1's "Admission of admitted to the facility. Wal Plan (RP) on 8/30/24 at the action the facility will take view at the deficient practice was returned to the view of the view of the view of the viewed viewed the viewed viewe	{F 5	50}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		((X3) DATE SURVEY COMPLETED	
		315124	B. WING			R-C 08/30/2024	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		00/00/202	•
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER		439 BELLEVUE AVENUE TRENTON, NJ 08618			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	PECTION	/VE	E)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		HOULD BE	D 4 T	ETION
{F 550}	Continued From page 16		{F 55	50}			
	NJAC 8:39-4.1(a) (11	-25) (27-29)					
F 557 SS=J		nt to have Prsnl Property	F 5	57		9/18/24	4
	§483.10(e) Respect a The resident has a rig and dignity, including	ght to be treated with respect					
	possessions, including as space permits, undupon the rights or hear residents. This REQUIREMENT by: Based on observation pertinent facility document that the facility failed dignified and respections.	ht to retain and use personal g furnishings, and clothing, ess to do so would infringe alth and safety of other is not met as evidenced n, interview, and review of ments, it was determined to ensure that were treated in a ful manner by resident from activities, community dining,		1. Resident #1 was immediate discharged from the facility. On 30th, 2024 the facility discontinu contracts with all NJ Ex Order 26. will no longer accept any NJ Ex Order 22. All Justice involved Resider	August ued 4(b)(1) ai		
	communicating with will, and retaining and possessions. This de identified for 1 of 1 Resident #1 was adm from the Resident #1 was obstheir room, not permitted to partic community dining. Renot allowed to leave the unless scheduled and	d using of personal ficient practice was (Resident #1). initted to the facility on by US FOIA (b)(6) e NJ Exec Order 26.4b1 erved being US FOIA (b)(6) erved being US FOIA (b)(6) and they were cipate in group activities and esident #1 stated they were heir room; have visitors d approved by the US FOIA (b) (c) d approved by the US FOIA (b) (c) d using of personal field (c) provided to the facility on the provided (c) provided to the provided (c) provided to the provided		the potential to be affected by the deficient practice. ¿ 3. On 8/30/2024 the Clinical Moperations conducted in-service education with all administrative the importance of ensuring that are treated in a dignified ¿ and remanner. ¿ ¿ 4. The Administrator/designee 5 residents a month x 4 months they are treated in a dignified ar respectful manner. Audit finding shared with the QAPI committee x 4 months. ¿	/P of e staff on resident espectful e will auc to ensuind gs will be	s dit re	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315124	B. WING			R-C 08/30/2024	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 439 BELLEVUE AVENUE TRENTON, NJ 08618	ODE	06/30/2024	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 557	meals in their room allowed use the tele which the resident being it day seven days a varietie television. Resident return to the better that the facility's failure including sexistence posed a limmediate Jeopard. The IJ began on 8/Administration was 4:29 PM. The facility Removal Plan (RR survey team verifier Removal Plan during on-site survey on 8 are revised 1/2/3/2016 S & C Nursing Facilities in autonomy and choice practicable regarding everyday lives and rights as nursing her allowed the facility of t	ticipate in activities; eat all on disposable ware; not ephone; and had reported feeling a room twenty-four hours a week with resolution and a target and they wanted to cause of it. To ensure all residents, the right to a dignified resolution and the right to a dignified resolution. 29/24, and the facility resident and they submitted an acceptable on 8/30/24 at 1:44 PM. The dath implementation of the right continuation of the ri	F	557			

OLIVILIY	O I OI (IVIL DIO) (I LL A	WEDIO/ ND CEITTIGEC				CIVID ITC	7. 0000 000 I
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		R	-C
		315124	B. WING				30/2024
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	, 55/	
				4	39 BELLEVUE AVENUE		
BELLE CA	RE NURSING AND REH	ABILITATION CENTER		Т	RENTON, NJ 08618		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 557	Continued From page	a 18	ļ	557			
	inform the resident ar		'	001			
	representative of the						
	· ·	all residents will be treated					
	-	age, race, ethnicity, religion,					
		ysical or mental disability,					
		s, sex, sexual orientation, or					
		pressionResident Rights: 1.					
		ight to a dignified existence,					
		nd communication with and					
	access to persons an	nd services inside and					
	outside the facility5	. the resident has the right to					
		ct and dignity including: the					
	right to be free from p	•					
		r the purpose of discipline or					
		right to retain and use					
	· ·	s [] the right to receive					
	services in the facility						
	accommodation of re						
		ght to share a room with a					
	roommate of his/her of	ne resident has the right to					
	and the facility must p						
	•	nation through support of					
		ding but not limited to; []					
		nedules [] consistent with					
		ht to make choices about					
	_	life that are significant to the					
	resident; interact with	-					
	•	risitors of their choosing at					
	•	singparticipate in other					
	activities including so						
	community activities						
		sident has the right to					
		confidentiality of their					
	personal and medical						
	environment: the resi	dent has the right to a safe,					
		nd homelike environment					
	On 8/29/24 at 9:45 Al	M, the surveyor observed a					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						1	-C
		315124	B. WING			08/	30/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
DELLE C	ARE NURSING AND REH	IABII ITATION CENTER			439 BELLEVUE AVENUE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER			TRENTON, NJ 08618		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 557	Continued From page	a 10		557	7		
1 007	. •			331			
	1 .	quipment (PPE) bin outside n. At that time, the surveyor					
	interviewed the Licen	•					
		ervisor #1), who stated					
		IJ Exec Order 26.4b1					
	[Nesident #1] had a	NS Exec Older 20.401					
	and when st	aff provided care, they					
	needed to don (wear)						
		ff had to wear PPE when the					
	resident was out of th						
	I .	that Resident #1 was a					
	who remained in their	r room unless to go to the					
		.4b1 The LPN Supervisor					
	#1 stated that Reside	ent #1 did not participate in					
		meals in their room on					
		Exec Order 26.4b1					
		led to be scheduled through					
	the by appointme	nt; and Resident #1 always					
		with US FOIA (b)(6).					
		#1 stated that the nurses					
	and Certified Nursing	· · ·					
	permitted in the room	to provide resident care.					
	On 8/29/24 at 9:55 A	M, the surveyor observed					
		ned with US FOIA (b)(6) US FOIA					
) who v						
	resident's door (US FOIA (I	and the resident's					
		hat time, the surveyor					
	interviewed Resident	#1, who stated they had					
	been at the facility NJ	Exec Order 26.4b1, and they					
	were receiving NJ Exec Orde	and NJ Exec Order 26.4b1 at the					
	facility. Resident #1 s	stated that they wanted to					
	return to the they						
	at the fac	ility because they remained					
		our hours a day, seven days					
		and a television. Resident					
	#1 stated they ate in	their room on disposable					
	ware and there were	no activities. Resident #1					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315124	B. WING				-C 30/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	IABILITATION CENTER	•	STREET ADDRESS, CITY 439 BELLEVUE AVENU TRENTON, NJ 08618	E	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 557	unless the was approving appointments. Reside waiting for grievance complain about it, whand the US FOIA (to come to the facility their weekly phone cannonth, so they misse and the resident wan NJ Exec Order 26.4 Resident #1 stated they received care they received care they received care they had visitors or present. Resident #1 to NJ Exec Order 26.4b1 them know they were a resident had to NJ Exec Order 26.4b1 them know they were a resident saw the resident saw the resident stated, "no", supposed to. At the time of the interesident saw the resident saw the resident stated, "no", supposed to. At the time of the interesident saw the resident saw the resident stated, "no", supposed to. At the time of the interesident saw the resident stated, "no", supposed to. At the time of the interesident saw the resident stated, "no", supposed to. At the time of the interesident saw the resident stated, "no", supposed to.	ey were prohibited visitors and the visits, and the otheir visitors for ent #1 stated they were paperwork from the paperwork from the visit to hich they had not received, b)(6) was supposed weekly so they could have all. Resident #1 stated the paper to the facility twice a country to the visit of the v	F	557			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		315124	B. WING_			R-C 08/30/2024
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CO 439 BELLEVUE AVENUE TRENTON, NJ 08618	I DE	00/30/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 557	NJ Exec Order 26	6.4b1	F 5	557		
	included the resident	at 7:37 AM, which was admitted to the facility A, accompanied by [USFOIA (5)(6)].				
	Data Set (MDS), an a	recent quarterly Minimum assessment tool dated resident had a brief status score of the out of 15, sident had an experience.				
	A focus area dated resident was not perm not landlines or cell p when the resident was not permitted to facility unless NJ Ex	phone use was permitted, ake care of it. The resident go out on pass or out of the ec Order 26.4b1 by ion was that the resident				
	than water pitcher (w	indicated to the control of the cont				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
						R-C	
		315124	B. WING _			08/30/2024	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
				439 BELLEVUE AVENUE			
BELLE CA	RE NURSING AND REH	ABILITATION CENTER		TRENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 557	A focus area dated resident had Intervention medications as order report as needed any my sician as NJ Exec Order 26.4b1 and mon physician as NJ Exec Order 26.4b1 a visco order 26.4b1 a visco order 26.4b1 and them, and there present. The stated that [Rest the NJ Exec Order 26.4b1] and that their room and use the The stated that their room and use the NJ Exec Order 26.4b1 and their room and use the NJ Exec Order 26.4b1 and their room and use the NJ Exec Order 26.4b1 and their room and use the NJ Exec Order 26.4b1 and their room and use the NJ Exec Order 26.	Exec Order 26.4b1 1. 26.4b1 1. 3. revealed that the with NJ Exec Order 26.4b1 1. si included to administer ed; monitor, document, and right signs and symptoms of itor, record, and report to ec Order 26.4b1 1. AM, the surveyor interviewed ited in NJ Exec Order 26.4b1 1. The sident #1] was transferred to week in the NJ Exec Order 26.4b1 1. The sident #1] did not er 26.4b1 because they stated that Resident rder 26.4b1 because they stated that Resident rder 26.4b1 in the NJ Exec Order 26.4b1 if the	F	557			
	On 8/29/24 at 11:55 A	AM, the surveyor interviewed					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315124	B. WING				-C
NAME OF D	ROVIDER OR SUPPLIER	313124	D. WING		REET ADDRESS, CITY, STATE, ZIP CODE	08/	30/2024
NAME OF F	ROVIDER OR SUFFLIER				B BELLEVUE AVENUE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER			RENTON, NJ 08618		
240.15	CLIMMADY CT	ATEMENT OF DEFICIENCIES			·		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 557	and staff did needed. The providing puzzles and surveyor asked if she Resident #1, and the did not see [Resident stated that there were were not really support could not provide any puzzles, or games. The requested a pack of pago, and the facility withat the provide and the facility with the provide and the p	stated activities as oups on both nursing units, der 26.4b1 activities as ed that NUEXCC Order 26.4b1 included d crossword puzzles. The provided stated that activity staff stated that activity staff in there and staff be seed to be in there; that she activities, crossword he stated [Resident #1] blaying cards about stated [Resident #1] blaying cards about vas not allowed to provide, to provide. PM, the surveyor interviewed ed CNA (CNA #1), who null exect order 26.4b1; that der 26.4b1 and go to the label and go to the label, and the resident was room to the shower room d the CNA provided the CNA #1 stated when it was just the resident in their ware with the label in their lab	F	557			

AND BLAN OF CORRECTION IN INDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			R-C 08/30/2024
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE	00/30/2024
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 557	the only time [Res and doctor's asked how often the appointments, and unsure if there wa #1] had an appoint that the NJ Exec accompanied [Res appointment. On 8/29/24 at 12:: Resident #1 sitting transported down The surveyor they were going, at the NJ Exec Order 26.4b1. Rappointment was a NJ Exec Order 26.4b1. Rappointment was a surveyor then obs US FOIA (I staff, use the elevation of the building. To [Resident #1] NJ since it was resident did NJ Exec Order 26.4b1. Staff, use the elevation of the building. To [Resident #1] was the NJ Exec Order 26.4b1. Staff, use the elevation of the building. To [Resident #1] was the NJ Exec Order 26.4b1. Staff, use the deviation of the building. To [Resident #1] was the NJ Exec Order 26.4b1. Staff, use the deviation of the building. To [Resident #1] was the NJ Exec Order 26.4b1. Staff, use the deviation of the building. To [Resident #1] was the NJ Exec Order 26.4b1. Staff, use the deviation of the building. To [Resident #1] was the NJ Exec Order 26.4b1.	with US FOIA (b)(6) r asked Resident #1 stated to see that NJ Exec Order 26.4b1 with US FOIA (b)(6) r asked Resident #1 stated to see that NJ Exec Order 26.4b1 with US FOIA (b)(6) r asked Resident #1 stated to see that NJ Exec Order 26.4b1 with US FOIA (b)(6) r asked Resident #1 stated to see that NJ Exec Order 26.4b1 esident #1 stated their at the hospital, and that their at the hospital, and that their at the Resident #1 stated "no". The served Resident #1 with US FOIA (b)(6) or over received the playing card and Resident #1 stated "no". The served Resident #1 with US FOIA (b)(6) or over received the playing card and Resident #1 stated "no". The served Resident #1 with US FOIA (b)(6) or over received the playing card and Resident #1 stated "no". The served Resident #1 with US FOIA (b)(6) or over received the playing card and Resident #1 stated "no". The served Resident #1 with US FOIA (b)(6) or over received the playing card and Resident #1 stated "no". The served Resident #1 with US FOIA (b)(6) or over received the playing card and Resident #1 stated "no". The served Resident #1 with US FOIA (b)(6) or over received the playing card and Resident #1 stated "no". The served Resident #1 with US FOIA (b)(6) or over received the playing card and Resident #1 stated "no". The served Resident #1 with US FOIA (b)(6) or over received the playing card and Resident #1 stated "no". The served Resident #1 with US FOIA (b)(6) or over received the playing card and Resident #1 stated "no".	F	557		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
						R-C	
		315124	B. WING _			08/30/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
BELLE CA	ARE NURSING AND REH	ABII ITATION CENTER		439 BELLEVUE AVENUE			
DLLLL OF	THE HOROMO AND INEM	ABIENATION SERVER		TRENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 557	with the with since with the were only at the and when their medic the were only at the and when their medic the were returned to that [Resident #1] state two were no provide playing cards stated the provide playing cards stated the were no private visits, and the resident wists, and the resident wists, and the resident wists, and that [Resident wists, and that [Resident #1] con were no private visits were no private visits and that [Resident #1] con were no private visits what [Resident #1] saw an NJ Exec Order 26 as a way were stated only [Resident #1] saw an NJ Exec Order 26 as a way were stated [Resident was all the oth they just did not have	who stated at the facility or stated that the facility for medical services, cal treatment was completed, the stated in their room with the saccompanied by the stated that the facility could not came to the facility she of for [Resident #1] to make a do not believe there was a stated that [Resident #1] to make a do not believe there was a stated that [Resident #1] to make a do not believe there was a stated that [Resident #1] to make a do not believe there was a stated that [Resident #1] to make a do not believe there was a stated that [Resident #1] to make a do not believe there was a stated that [Resident #1] to make a do not believe there was a stated that [Resident #1] to make a do not believe there was a stated that [Resident #1] to make a do not believe there was a stated that [Resident #1] to make a do not believe there always ent #1] could not have a visitor red it. The stated there were always ent #1] could not be without do it was the stated them order 26.4b1. The stated them order 26.4b1 that identified them order 26.4b1 that the could be in ansportation, and [Resident order 26.4b1 that the cheduled by the stated the same stated that the cheduled by the stated the same stated that the cheduled have seen the der 26.4b1. The stated the same stated that the cheduled by the stated the same stated that the cheduled by the stated that the cheduled	F	557			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		315124	B. WING _				-C 30/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	1 00/	00/2024
				439 BELLEVUE AVENUE			
BELLE CA	ARE NURSING AND REI	IABILITATION CENTER		TRENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 557	that. The stated control of [Resident a everything else was On 8/29/24 at 1:30 F facility's policies regathe following: A review of the "Inmadated 8/21/23, including [facility] to provide must supports establish Procedure: 1. all inmand snacks and dineresident meals will be paper goods; 3. all inserved with plastic unever permitted; 4. puthe inmate resident to offered the opportunis no food or drinks of (when clinically approximately approximate	Ind the facility did not control of that the facility was in the facility which included the facility which included the facility of the facility protocols. The facility protocols was will receive their meals in their room; 2. all inmate the served on disposable facility in the facility of meal tray to the CO in attendance will be the facility to check the tray There of the than a water pitcher for the facility was in the facility was in the facility of meal tray to the CO in attendance will be the facility of the facility of the facility was in the facility of the fac	F	557			
	_	d 9/12/23, included that COs					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315124	B. WING _		,	R-C 08/30/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REF	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		30/30/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIDE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 557	An acceptable Remoderated 1:44 PM indicated that to NJ Exec Order The faci action plan to remedincluding the resident to accept to accept were inserviced memo regarding responsible for the in policies and regulation. The survey team verification of the survey team verification and regulation.	aval Plan (RP) on 8/30/24 at the action the facility will take 26.451 lity implemented a corrective state the deficient practice to the deficient p	F5	557			
F 561 SS=J	S483.10(f) Self-deter The resident has the promote and facilitate through support of renot limited to the right (1) through (11) of the \$483.10(f)(1) The reactivities, schedules waking times), health	mination. right to and the facility must e resident self-determination esident choice, including but ats specified in paragraphs (f) is section. sident has a right to choose (including sleeping and a care and providers of health tent with his or her interests,	F 5	61		9/18/24	

		COMPLETED	
315124 B. WING		R-C 08/30/2024	
NAME OF PROVIDER OR SUPPLIER BELLE CARE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	(X5) COMPLETION DATE	
Applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to promote and facilitate resident self-determination through support of resident choice including to; participate in group activities, community dining, serving meals in a dignified manner, freely communicate with visitors, leave room at will, be free from and wear clothing of choice for and they seed that was observed being their room, we seed that the facility on and they Resident #1 was not permitted to participate in group activities and community dining. Resident	1. Resident #1 was immediately discharged from the facility. On August 30th, 2024 the facility discontinued contracts with all Sexec Order 26.4b1 ar will no longer accept any Sexec Order 26.4b1 ar will no longer accept any Lexec Order 26.4b1 ar will no longer accept any Sexec Order 26.4b1 ar will no longer accept any	it e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '		(X3) DATE SURVEY COMPLETED		
	315124	B. WING		R-C 08/30/2024		
ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	, 35.33.222		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
approved by the clothes having to vactivities; eat all m disposable ware; rand had feeling "NJ Exec O twenty-four hours atwo and a telewanted to return to two and a telewanted to return to the facility's failure resident self-determine their room at will, of choice, and wear of their room at will, of their room at will, of their room at will, of their room at will respect to their room at	could not choose their own wear an NJ Exec Order 26.4b1 participate in eals in their room on not allowed use the telephone; which the resident reported reder 26.4b1 "being in a room a day seven days a week with evision. Resident #1 stated they the because of it. It to promote and facilitate mination through support of all residents, including activities and dining, leave communicate with visitors of clothing of choice posed a and . This resulted in an andy (IJ) situation. It is notified of the IJ on 8/29/24 at it it submitted an acceptable on 8/30/24 at 1:44 PM. The ad the implementation of the ing the continuation of the	F 56	.1			
Reference: The Ce Medicaid Services Surveyors on Fede services to Justice 12/23/2016 S & C	enters for Medicare and (CMS) updated Guideline to eral Requirements for Providing Involved individuals, revised 16-21-ALL documented Skilled					
	Continued From participate in group their room at will, choice, and wear continued to return to the facility's failure resident choice for participate in group their room at will, choice, and wear continued to return to the facility's failure resident choice for participate in group their room at will, choice, and wear continued to return to the facility's failure resident choice for participate in group their room at will, choice, and wear continued for the facility is failured by the facility is fai	ARE NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 approved by the could not choose their own clothes having to wear an participate in activities; eat all meals in their room on disposable ware; not allowed use the telephone; and had subsection which the resident reported feeling "NJ Exec Order 26.4b1" being in a room twenty-four hours a day seven days a week with two subsections and a television. Resident #1 stated they wanted to return to the subsection through support of resident choice for all residents, including resident choice for all residents, including to participate in group activities and dining, leave their room at will, communicate with visitors of choice, and wear clothing of choice posed a	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 approved by the could not choose their own clothes having to wear an participate in activities; eat all meals in their room on disposable ware; not allowed use the telephone; and had cheefeling by Exec Order 26.451 because of it. The facility's failure to promote and facilitate resident self-determination through support of resident choice for all residents, including and their room at will, communicate with visitors of choice, and wear clothing of choice posed a ly Exec Order 26.451 and ly Exec Order	ROWIDER OR SUPPLIER ARE NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)) Continued From page 29 approved by the could not choose their own clothes having to wear an INJECT OR SUBJECT OF STATE AND SUBJECT OR SUB		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		315124	B. WING			08/	30/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 39 BELLEVUE AVENUE RENTON, NJ 08618		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 561	everyday lives and rerights as nursing home and review of the facility revised 1/3/24, including treated equally regarded equally regarded equally regarded expressionResiden the right to a dignified self-determination, and access to persons and outside the facility6 resident has the right promote and facilitate through support of renot limited to; [] cho consistent with their in choices about aspect significant to the resident has the right promote and facilitate through support of renot limited to; [] cho consistent with their in choices about aspect significant to the resident for the community; reconsing at the time in other activities included community activities. confidentiality: the respersonal privacy and personal and medical environment: the resident, comfortable and On 8/29/24 at 9:45 A personal protective end of Resident #1's room interviewed the Licent Supervisor (LPN Supervisor (LPN Supervisor).	how they wish to live their receive care with the same ne residents. y's "Resident Rights" dated led10. all residents will be dless of age, race, ethnicity, uage, physical or mental omic status, sex, sexual ridentity or t Rights: 1. the resident has dexistence, and communication with and and services inside and and services inside and a services inside and a services inside and a services including but be resident self-determination sident choice including but be a cativities, schedules [] interests; the right to make a so f his or her life that are dent; interact with members be review visitors of their of their choosingparticipate and under the social, religious, and under the services and sident has the right to confidentiality of their larecords9. Safe dent has the right to a safe, and homelike environment M, the surveyor observed a quipment (PPE) bin outside in. At that time, the surveyor	F	561			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	' '	ATE SURVEY OMPLETED
						R-C
		315124	B. WING _			08/30/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
DELLE O	DE NUBOINO AND DEU	A DII ITATION CENTED		439 BELLEVUE AVENUE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER		TRENTON, NJ 08618		
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 561	[Resident #1] was our Supervisor #1 stated who remained in their NJ Exec Order 26. #1 stated that [Resid activities; ate all their disposable ware; NJ visitors need	, they additional PPE. The f had to wear PPE when t of the room, and the LPN that [Resident #1] was a room unless to go to the 4b1. The LPN Supervisor ent #1] did not participate in meals in their room on Exec Order 26.4b1 led to be scheduled through	F 5	561		
	the by appointment; and that [Resident #1] always remained in the Newcool of The LPN Supervisor #1 stated that the nurses and Certified Nursing Aides (CNAs) were permitted in the room to provide resident care. On 8/29/24 at 9:55 AM, the surveyor observed Resident #1 lying in bed with US FOIA (b)(6) who were					
	resident's door (window (window (window)) At the interviewed Resident been at the facility were receiving facility. Resident #1 stated they at the facility at the facility were were with ware and there were stated that they were the wife approved the responding to their vis Resident #1 stated th	and the resident's mat time, the surveyor #1, who stated they had now, and they and secondar 26.4b1 now, and they and secondar care at the tated that they wanted to were sility because they remained our hours a day, seven days and a television. Resident their room on disposable no activities. Resident #1 prohibited visitors unless visits, and the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			R-0 08/3	C 8 0/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REF	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 439 BELLEVUE AVENUE TRENTON, NJ 08618	ODE	00/0	VOI 202-
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	E ACTION SHOULD BE D TO THE APPROPRIATE		(X5) COMPLETION DATE
F 561	to the facility weekly weekly phone call. Remaybe came to they missed their allor resident wanted to cobe weekly Exec Order 26.4b1 they had they made a call, the surveyor asked and the resident state. The surveyor asked facility's surveyor asked facility's and they thought they weekly surveyor asked facility's if everything they accurate, and the was surveyor asked facility if everything they accurate, and the was surveyor asked facility if everything they accurate and the was surveyor asked facility if everything they accurate and the was surveyor asked facility if everything they accurate and the was surveyor asked facility if everything they accurate and the was surveyor asked facility if everything the accurate and the was surveyor asked facility in the surveyor asked facility is surveyor asked facility in the surveyor asked facility in the surveyor asked facility is surveyor asked facility in the surveyor asked facility in the surveyor asked facility is surveyor asked facility in the surveyor asked facility is surveyor asked facility in the surveyor asked facility is surveyor asked facility in the surveyor asked facility is surveyor asked facility in the surveyor asked facility is surveyor asked facility in the surveyor asked facility in the surveyor asked facility is surveyor asked facility in the surveyor	nad not received, and the) was supposed to come so they could have their desident #1 stated the the facility twice a month, so owed phone calls, and the all their Resident #1 stated anytime they received care room, and if they had visitors were present. Resident they went to request to they were present they wore r 26.4b1 The know they were a resident they wore in the room or in red, "no", NJ Exec Order 26.4b1 if the resident saw the resident stated, "no", but they were supposed to. The surveyor asked the resident reported was stated "yes", the resident AM, the surveyor reviewed	F	561	·**)		
	included but not limit A review of the Prog	facility with diagnoses which ed to; NJ Exec Order 26.4b1 ress Notes included a JEXAC OTAGE 26.4b1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315124	B. WING			R-C	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO 439 BELLEVUE AVENUE TRENTON, NJ 08618		8/30/2024	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 561	A review of the m Data Set (MDS), reflected interview for men indicating that the large of the implan (ICCP) included a focus area date resident was not permitted facility unless US the large of the implant of the store of the implant of the impla	ost recent quarterly Minimum an assessment tool dated the resident had a brief call status score of out of 15, a resident had an areas: Comparison of the field of the following focus areas:	F	561			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE S	
		315124	B. WING			R-	
NAME OF P	ROVIDER OR SUPPLIER	315124	B. WING _	STREET ADDRESS, CITY		08/3	30/2024
				439 BELLEVUE AVENU	, , , , , , , , , , , , , , , , , , , ,		
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER		TRENTON, NJ 08618	В		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD E RENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From page	e 34	F 5	661			
	report as needed any	ed; monitor, document, and signs and symptoms of itor, record, and report to ec Order 26.4b1					
	the US FOIA (b) (6 Resident #1 participa NJ Exec Order 26.451 times a v US FOIA (t) stated that [Res the NJ Exec Order 26.451 by US FOIA with them, and there present. The US FOIA (t) sta require NJ Exec O "" #1 was NJ Exec O "" " #1 was NJ Exec O " " " " " " " " " " " " " " " " " "	week in the NJ Exec Order 26.4b1 . The sident #1] was transferred to who always remained were no other residents ated [Resident #1] did not reder 26.4b1 . The sident #1] and NJ Exec Order 26.4b1 . The sident #1] was currently 5.4b1 . The the NJ Exec Order 26.4b1 if stated and the NJ Exec Order 26.4b1 if					
	the facility's who at the facility NJ Exec Order 28 speak to all the reside	ents yet. The surveyor asked Resident #1, and she stated					
	the US FOIA (b)(6) were conducted in grand staff did NJ Exeneeded. The providing puzzles and	oups on both nursing units, c Order 26.4b1 as					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ı	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315124	B. WING			1	-C 30/2024	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		439	REET ADDRESS, CITY, STATE, ZIP CODE BELLEVUE AVENUE ENTON, NJ 08618	1 00/	30/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 561	did not see [Residen stated that there wer were not really supported to be stated that there were were not really supported to be stated to be stated a pack provide, that the stated the NJ Exec Order 26. Permitted out of their with the SFOIA (B)(6) and the stated that the stated the NJ Exec Order 26. Permitted out of their with the SFOIA (B)(6) are washcloth and towel [Resident #1] NJ EXEC ORDER (B) SFOIA (B)(6) are washcloth and towel [Resident #1] always [Resident #1] always	stated that activity staff t #1] that often. The set of the interest of the set of the interest of the set of playing cards about a facility was not allowed to had to provide. PM, the surveyor interviewed and CNA (CNA #1), who	F	561				
	the NJ Exec Order that [Resident #1] NJ Exec Order 2 the NJ Exec Order that [Resident 31] sathe facility because there were always U #1], and the only time room was for The surveyor asked	The LPN #1 stated or 26.4b1 , and w a NJ Exec Order 26.4b1 . The LPN #1 stated that S FOIA (b)(6) with [Resident et [Resident #1] left their and doctor's appointments. how often the resident had 6.4b1, and the LPN #2						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			R-C 08/30/2024	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 439 BELLEVUE AVENUE TRENTON, NJ 08618	•	00/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 561	appointment setup the trans accompanied Resappointment. On 8/29/24 at 12:: Resident #1 sitting transported down The surveyor they were going, at the NJ Exec Order 26.4bl, as appointment was NJ Exec Order 26.4bl, as appointment was NJ Exec Order 26. Resident #1 if they requested, as surveyor then obsurveyor the since it was resident #1] need since it was resident #1] need since it was resident #1] need since it was resident #1] was the s	[Resident #1] had an The LPN #2 stated that the sportation, and the sportation ident #1 to and from the BO PM, the surveyor observed in a wheelchair being the hallway sport asked Resident #1 where and Resident #1 stated to see that they sport asked their at the hospital, and that their sport asked where the playing card and Resident #1 stated "no". The surveyor asked where the sport and no residents or actor to go downstairs. Burveyor asked sport that the sport dearlier that the spo	F	561			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION		E SURVEY IPLETED
						F	₹- C
		315124	B. WING _			90	3/30/2024
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
RELLE C	ARE NURSING AND REH	ARII ITATION CENTER		439 B	ELLEVUE AVENUE		
BLLLL C	AND NORSING AND NEIT	ABIETATION CENTER		TREN	ITON, NJ 08618		
(X4) ID PREFIX TAG			ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 561	and when their medic the Note of that Resident #1 stay and went to The Secondary and Secondary	facility for medical services, cal treatment was completed, the stated red in their room with the accompanied by them. It everything was controlled cility could not provide usage; visitors. The stated that the facility she for [Resident #1] to make a rid not believe there was a stated that the resident red it. The stated that a the stated there, that there were always followed it was the stated them order 26.4b1. The stated that identified them order 26.4b1. The stated by the stated that the stated by the stated that the stated them order 26.4b1 that identified them order 26.4b	F	561			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		315124	B. WING_			R-C		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 439 BELLEVUE AVENUE	ZIP CODE	08/30/2024		
BELLE CA	ARE NURSING AND R	EHABILITATION CENTER		TRENTON, NJ 08618				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
F 561	admission agreem On 8/29/24 at 1:30 facility's policies re the following: A review of the "Initiated 8/21/23, incl [facility] to provide that supports estat Procedure: 1. all in and snacks and diresident meals will paper goods; 3. all served with plastic never permitted; 4. the inmate residen offered the opportuis no food or drinks (when clinically appeared to access cell phones; 2. the the inmate room properties in the inmate room properties at the	d a copy of the resident's ent and resident rights. PM, the surveyor reviewed the garding which included mate Resident Dining" policy uded it is the policy of the meals and snacks in a manner plish security protocols. In their room; 2. all inmate be served on disposable inmate resident meals will be utensils; metal utensils are prior to delivery of meal tray to the CO in attendance will be unity to check the tray7. there is other than a water pitcher proved) be stored at bedside mate Phone Use" policy dated inmates are not routinely stelephones, not landlines or landline will be removed from from to admission; 3. the staff is participate in allowing inmates; 4. in rare circumstances when the ermitted this will be entirely to time is [facility] staff to	F	561				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		315124	B. WING _		R-C 08/30/2024
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	00/30/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER OF THE	D BE COMPLETION
F 561	survey team that she have the inform the to visit the resident are An acceptable Removed 1:44 PM indicated the to NJ Exec Order	M, the informed the had spoken to the facility who was permitted and when. Val Plan (RP) on 8/30/24 at exaction the facility will take	F 5	61	
	action plan to remedia including the resident including the resident including the resident including the resident including to accept to accept including i	was returned to the was returned to the on one of the contract with the has no other contracts with ept state of the state			
		fied the implementation of ring the continuation of the 0/24.			
F 603 SS=J	§483.12 The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's me	right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms.	F 6	03	9/18/24
	§483.12(a) The facilit	y must-			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE COMP	SURVEY LETED
		315124	B. WING _				-C 30/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		1 00/	50/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 603	physical abuse, corpor involuntary seclusion. This REQUIREMENT by: Based on observation pertinent facility document facility failed shall be pertinent facility failed shall be practice was identified shall be practiced was identified shall be practiced and was shall be practiced and community dining were not allowed to levisitors unless schedules could not choose shall be permitted to and community dining were not allowed to levisitors unless schedules could not choose shall be permitted to allowed use the telep which the resident res	e verbal, mental, sexual, or oral punishment, or is not met as evidenced is not met as evidenced in, interview, and review of ments, it was determined to ensure all residents were ding the Useco Order 26.4b1 for a 6.4b1 This deficient d for 1 of 1 This deficient (Resident (Resident #1) by Nusco Order 26.4b1 for a 6.4b1; Resident #1 participate in group activities g. Resident #1 stated hey eave their room; have used and approved by the their own clothes having to 6.4b1 sipate in activities; eat all in disposable ware; not	F 6	,	On August inued 26.4(b)(1) a Order 26.4(b) dents have this I VP of vice ive staff of at resident usion. ¿ the will auths to ensure seclusion with the Q	and (1) e n tts dit ure n.	
	The facility's failure to including were from NJ Exec Order 26.4b1						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL1 A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		315124	B. WING _			R-C 08/30/2024	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 439 BELLEVUE AVENUE TRENTON, NJ 08618	•	00/30/2024	
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F 603	Immediate Jeopard The IJ began on 8/2 Administration was 4:29 PM. The facilit Removal Plan (RR) survey team verified Removal Plan durir on-site survey on 8. The findings were a Reference: The Ce Medicaid Services of Surveyors on Fede services to Justice 12/23/2016 S & C 1 Nursing Facilities mautonomy and choic practicable regardir everyday lives and rights as nursing ho A review of the facil revised 1/3/24, inclute the facility, socioecon orientation, or gend expressionReside the right to a dignification, access to persons a outside the facility be treated with resp	26.4b1 . This resulted in an y (IJ) situation. 29/24, and the facility notified of the IJ on 8/29/24 at by submitted an acceptable on 8/30/24 at 1:44 PM. The did the implementation of the ing the continuation of the right of the continuation of the right of the implementation of the right of the implementation of the right of the implementation of the right of the r	F	603			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		315124	B. WING			08/	30/2024	
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BELLECA	DE NUDCINO AND DE	HARII ITATION CENTER		4	39 BELLEVUE AVENUE			
BELLE CA	IKE NUKSING AND KE	HABILITATION CENTER		1	FRENTON, NJ 08618			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)	
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F 603	Continued From no	vo 40		000				
F 003	Continued From pag		F	603				
		right to retain and use						
	T	ns [] the right to receive						
	services in the facilit	<u> </u>						
	accommodation of r							
		ight to share a room with a						
	roommate of his/her							
		the resident has the right to						
		promote and facilitate						
	resident self-determination through support of resident choice including but not limited to; []							
	choose activities, schedules [] consistent with							
	their interests; the right to make choices about							
	aspects of his or her life that are significant to the							
	resident; interact wit	——————————————————————————————————————						
		visitors of their choosing at						
	· ·	osingparticipate in other						
	activities including s	- · ·						
	community activities							
		esident has the right to						
	personal privacy and	d confidentiality of their						
	personal and medica	al records9. Safe						
	environment: the res	sident has the right to a safe,						
	clean, comfortable a	and homelike environment						
		ty's "Abuse Prevention" policy						
		2024, included it is the policy				ĺ		
		erate any form of resident						
		xploitation by staff members,						
		or family members, or by						
		e facility will have an abuse						
		that protects residents from				ĺ		
		abuse [] in compliance with				ĺ		
		egulationsInvoluntary				ĺ		
	-	ation of a resident from other				ſ		
		s/her room, or confinement to				ĺ		
	•	t resident's will or against the				ĺ		
		le partyResident Bill of				ĺ		
		home resident in the State of				ĺ		
	inew Jersey, you na	ve the following rights:[]	1					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		315124	B. WING			R-C		
NAME OF D	ROVIDER OR SUPPLIER	313124	1 2:	STREET ADDRESS, CITY, STATE, ZIP CO		08/	30/2024	
NAME OF FI	NOVIDER OR SUFFLIER				DE			
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER		439 BELLEVUE AVENUE				
				TRENTON, NJ 08618				
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F 603	Continued From page	e 43	F 6	603				
	physical and mental a	al restraints, unless they are ician for a limited period of						
	dated effective Octobe will be used only whe symptoms and not us The least restrictive r duration of time will be resident in reaching t and psychosocial we but are not limited to [] leg restraintsGu plan to ensure that re interventions have be consideration of the r physician's order for Physical Restraint Infe	pic: Restraint Management" per 2021, included restraints en necessary to treat medical sed for staff convenience. estraint for the shortest e applied to assist the heir highest level of physical ll-beingrestraints include, the following: arm restraints uidelines: 1. evaluate care estraint alternative een tried prior to eestraint4. obtain a restraint [] 5. provide the formation Sheet to the le party [] 6. review and						
	revised May 2024, in residents to receive versident's wishes and of other residents in the contact with the common or is familiar. Proceding may visit the resident protection of the right residents and any resident5. residents the clergy at any time	If the protection of the rights the facility to maintain the munity in which he/she lived ture: 1. the resident's family that any time subject to the						

(X3) DATE SURVEY COMPLETED		
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ECTION (X5) HOULD BE COMPLETION PROPRIATE DATE		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315124 B. WING				R-C 08/30/2024	
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F 603	#1 stated they are ware and there we stated that they we the stated that they we the stated that they we the stated that they we approved the stated grievance paperwork about it, which they maybe came to they missed their a resident wanted to be NJ Exec Order they had the stated that whe an NJ Exec Order they had the surveyor aske and the resident stated that whe an NJ Exec Order asked and the resident stated that whe an NJ Exec Order asked and the resident stated that whe an NJ Exec Order asked and the resident stated that whe and the surveyor asked and the resident stated that whe and the surveyor asked and the resident stated that whe and the surveyor asked and the resident stated that was and the was supplied or the Adamission summan was admitted to the state of the Adamission summan was admitted to the state of the Adamission summan was admitted to the state of the Adamission summan was admitted to the state of the Adamission summan was admitted to the state of the Adamission summan was admitted to the state of the Adamission summan was admitted to the state of the Adamission summan was admitted to the state of the Adamission summan was admitted to the state of the Adamission summan was admitted to the state of the Adamis admitte	and a television. Resident in their room on disposable re no activities. Resident #1 are prohibited visitors unless the visitors for appointments. If they were waiting for ork from the was supposed to come was supposed to come by so they could have their and the call their was supposed to come was supposed to come by so they could have their and the call their was supposed to come was supposed to come by so they could have their and the call their was supposed to come was supposed to come by so they could have their and they was supposed to come was supposed to come by so they could have their and they was supposed to come by so they could have their and they was supposed to come by so they could have their and they was to request to or equest to be call which was supposed to come by so they could have their and they were and if they had visitors were present. Resident they wore were and if they wore were and if the resident was allowed by the resident reported was stated "yes", the resident was stated "yes", the resident and the resident was stated "yes", the resident and the resident was stated "yes", the resident was stated "yes", the resident and the resident was stated "yes", the resident was sta	F	503			

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F 603	A review of the Pr Nursing Note date included the resid on at 6:55 The resident was A review of the modern pata Set (MDS), and the indicating that the	ogress Notes included a ed Newsoneral at 7:37 AM, which ent was admitted to the facility 5 PM, accompanied by admitted with a Newsoneral admitted with a Newsoneral admitted with a newsoneral assessment tool dated the resident had a brief cal status score of out of 15, resident had an newsoneral accordance and the resident had an newsoneral accordance and the resident had an new review reflected the resident	F	503				
	A focus area date was not permitted landlines or cell p w the was not permitted facility unless NJ the The intervention of the state of the intervention of the interv	hen phone use was permitted, aff take care of it. The resident to go out on pass or out of the Exec Order 26.4b1 by vention was that the resident by the						

NAME OF PROVIDER OR SUPPLIER BELLE CARE NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG Continued From page 47 was the resident would NU Exec Order 26.4b1 and be NU Exec Order 26.4b1 Interventions were to educate resident/family/caregivers about risks, benefits, and NU Exec Order 26.4b1 A focus area dated medications as ordered by physician; monitor and record occurrence of target behavior and symptoms; and NU Exec Order 26.4b1 Interventions included to educate the resident used Nu Exec Order 26.4b1 Interventions included to educate the resident/family/caregivers about risks, benefits, and NU Exec Order 26.4b1 Interventions included to educate the resident/family/caregivers about risks, benefits, and NU Exec Order 26.4b1 Interventions included to educate the resident/family/caregivers about risks, benefits, and NU Exec Order 26.4b1 Interventions included to educate the resident/family/caregivers about risks, benefits, and NU Exec Order 26.4b1 Interventions included to educate the resident used NU Exec Order 26.4b1 Interventions included to educate the resident used NU Exec Order 26.4b1 Interventions included to educate the resident used NU Exec Order 26.4b1 Interventions included to educate the resident used NU Exec Order 26.4b1 Interventions included to educate the resident used NU Exec Order 26.4b1 Interventions included to educate the resident used NU Exec Order 26.4b1 Interventions included to educate the resident used NU Exec Order 26.4b1 Interventions included to educate the resident used NU Exec Order 26.4b1 Interventions included to educate the resident used NU Exec Order 26.4b1 Interventions included to educate the resident used NU Exec Order 26.4b1 Interventions included to educate the resident used NU Exec Order 26.4b1 Interventions included to educate the resident used NU Exec Order 26.4b1 Interventions included to educate the resident used NU Exec Order 26.4b1	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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was the resident would NJ Exec Order 26.4b1 and be NJ Exec Order 26.4b1 A focus area dated Interventions were to educate resident/family/caregivers about risks, benefits, and NJ Exec Order 26.4b1; give redications as ordered by physician; monitor and record occurrence of target behavior and symptoms; and NJ Exec Order 26.4b1 A focus area dated NJ Exec Order 26.4b1 A focus area dated redication with regards to NJ Exec Order 26.4b1 Interventions included to educate the resident/family/caregivers about risks, benefits, and NJ Exec Order 26.4b1; give redications as ordered by medications as ordered by	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP				COMPLETION
physician; monitor, document, and report to physician as needed any ongoing signs and symptoms of the control o	F 603	was the resident wou and be NJ Exec Order A focus area dated used NJ Exec Order Interesident/family/caregiand NJ Exec Order and symptoms; and medication monitor and record or and symptoms; and NJ Exec Order 26.4b1 Intervent resident/family/caregiand NJ Exec Order 26.4b1 medication physician; monitor, do physician; monitor, do physician as needed symptoms of NJ Exec Order 26.4b1 medication physician as needed symptoms of NJ Exec Order 26.4b1 medication physician; monitor, do physician as needed symptoms of NJ Exec Order 26.4b1 medication physician as needed symptoms of NJ Exec Order 26.4b1 medication physician; monitor, do physician as needed symptoms of NJ Exec Order 26.4b1 medication physician as needed symptoms of NJ Exec Order 26.4b1 medication physician as needed symptoms of NJ Exec Order 26.4b1 medication physician as needed symptoms of NJ Exec Order 26.4b1 medication physician as needed symptoms of NJ Exec Order 26.4b1 medication physician as needed symptoms of NJ Exec Order 26.4b1 medication physician as needed symptoms of NJ Exec Order 26.4b1 medication physician as needed symptoms of NJ Exec Order 26.4b1 medication physician as needed symptoms of NJ Exec Order 26.4b1 medication physician as needed symptoms of NJ Exec Order 26.4b1 medication physician as needed symptoms of NJ Exec Order 26.4b1 medication physician p	Id NJ Exec Order 26.4b1 26.4b1 revealed the resident er 26.4b1 reventions were to educate vers about risks, benefits, give one as ordered by physician; ccurrence of target behavior JJ Exec Order 26.4b1	F	603			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER	•	•	STREETA	DDRESS, CITY, STATE, ZIP CODE			
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BELLE C	ARE NURSING AND REH	ABILITATION CENTER		TRENTO	N, NJ 08618			
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F 603	A review of the NJ Exec Order 2, included that for a follow-u. "NJ Exec Order 26-459 and SI Exec Order 26-459 and Exec Ord	the resident was seen p visit. The resident reported 26.4b1 Intreported feeling The reported feeling The reported feeling The resident reported 26.4b1 The resident reported 26.4b1 The resident reported 26.4b1 The reported feeling The resident reported The reported feeling The repor	F	503				

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F 603	was to facility could not start the US FOIA (b) were conducted in and staff did NJ Execution needed. The start were not really she could not providing puzzles, or games requested a pack of ago, and the facility that the stated [Resident #1's] assistated [Resident #1's] assistated [Resident #1'with start of the washcloth and [Resident #1] NJ Execution with the start with start of the washcloth and [Resident #1] NJ Execution with the start of the washcloth and [Resident #1] always room on disposable room.	was working with stated that the stated that the stated activities groups on both nursing units, activities as acted that activities for the provided stated that activities for the provided stated that activities, crossword stated that activities, crossword in there and a supposed to be in there; that de any activities, crossword the stated [Resident #1] of playing cards about a stated that [Resident #1] of playing cards about a stated that [Resident #1] always stayed in their room the shower stated that [Resident #1] of their room to the shower stated that [Resident #1] of their stat	F	603				
	the LPN #1 in the p	O PM, the surveyor interviewed presence of LPN #2, who ant #1] received NU Exec Order 26.451 for 26.451						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
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			TRI	ENTON, NJ 08618			
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the wound was the Resident #1] saw a facility because they really saw a facility because they really says US FOIA (b) (6) the only time [Resident #1] had an appointment and the surveyor as they were going, and the NJ Exec Order 26.4b1 resident if they ever really requested, and Facility saff, use the elevator At that time, the surveyor as they they requested and Facility saff, use the elevator At that time, the surveyor Resident #1] needed	The LPN #1 stated J Exec Order 26.4b1, and J Exec Order 26.4b1 outside the refused to see the facility's 1 stated that there were with [Resident #1], and the #1] left their room was for repointments. The surveyor sident #1] had W Exec Order 26.4b1 PN #2 stated she was set schedule, but [Resident ent " LPN #2 stated transportation, and the ent #1] to and from the PM, the surveyor observed a wheelchair being 3.4b1 sked Resident #1 where Resident #1 stated to see at they W Exec Order 26.4b1 dent #1 stated their he hospital, and that their he decived the playing card Resident #1 stated "no". The head Resident #1 with head Resident #1 why head Resident #1	F	603				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER ARE NURSING AND REH	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 439 BELLEVUE AVENUE TRENTON, NJ 08618)E	, 50.	<u> </u>
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F 603	the stated on a new surveyor observed Rout of the building by On 8/29/24 at 12:45 to review the medical A review of the Orderinclude a PO for the State of S	PM, the surveyor did not use of NJ Exec Order 26.4b1 I did include a focus area for PM, the surveyor interviewed	F	503			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION S	(X3) DATE SURVEY COMPLETED				
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F 603	them. The state and [Resident #1] constant [Resident #1] saw at the elevator during the appointments were stated [Resident #1] saw at the appointments were stated [Resident #1] saw at the appointments were stated [Resident #1] saw at the appointment were stated that Resident #1 as all the out they just did not have stated that [Resident #1] stated that [Resident #1] state control of [Resident #1] sta	"The "The "SPOINT Could be in cansportation, and that "J Exec Order 26.4b1" that the ere scheduled by the "The ent #1] saw the facility's ed and could have seen the #1 received the same "H received the same ener residents in the facility,"	F 60	03				

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	ROVIDER OR SUPPLIER	L	B. WING	STREET ADDRESS, CITY 439 BELLEVUE AVENU TRENTON, NJ 08618	E	08/3	30/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 603	is no food or drinks of (when clinically approximated to access to cell phones; 2. the lar the inmate room prior not to facilitate or parto use a telephone; 4 telephone use is pernatken care of by the [assigned COs; 5. at reparticipate in inmate's On 8/29/24 at 3:05 Pl survey team that she have the inform that to visit the resident are An acceptable Removed 1:44 PM indicated the to NJ Exec Order The facilitation plan to remediate including the resident and additional including the resident and additional were inserviced memo regarding were inserviced memo regarding responsible for the impolicies and regulation. The survey team verification in the survey team verification of the impolicies and regulation.	ther than a water pitcher eved) be stored at bedside It e Phone Use" policy dated mates are not routinely elephones, not landlines or addine will be removed from to admission; 3. the staff is ticipate in allowing inmates. In rare circumstances when mitted this will be entirely CF staff], specifically the to time is [facility] staff to sphone use. M, the facility informed the had spoken to the had spoken to the facility who was permitted and when. It is implemented a corrective attempt of the deficient practice was NJ Exec Order 26.4b1 on add their contract with the has no other contracts with the has no other contracts.	F	603			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		315124	B. WING _		R-C 08/30/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 439 BELLEVUE AVENUE TRENTON, NJ 08618	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION DATE
F 603	Continued From page	2 54	F 6	603	
F 604 SS=J	NJAC 8:39-4.1(a)(5)(Right to be Free from CFR(s): 483.10(e)(1)	Physical Restraints	F 6	604	9/18/24
	§483.10(e) Respect a The resident has a rig and dignity, including	ght to be treated with respect			
	physical or chemical purposes of discipline	ht to be free from any restraints imposed for e or convenience, and not esident's medical symptoms, 12(a)(2).			
	neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to			
	from physical or chen	y must- that the resident is free nical restraints imposed for or convenience and that			
	are not required to tre symptoms. When the indicated, the facility alternative for the lea document ongoing re restraints. This REQUIREMENT by:	eat the resident's medical use of restraints is must use the least restrictive st amount of time and evaluation of the need for is not met as evidenced			
		n, interview, and review of ments, it was determined		Resident #1 was imn discharged from the facili	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	315124	B. WING _			R-C 08/30/2024	
NAME OF PROVIDER OR SUPPLIER BELLE CARE NURSING AND R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618			
PRÉFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
NJ Exec Order imposed or imposed or This deficient of 1 [Resident #1 was a NJ Exec Order observed being by [Is Fold (b)(6)], and R to participate in grodining. Resident #1 allowed to leave the scheduled and appactivities; eat all modisposable ware; nand had [reeling NJ Exec Ortowenty-four hours at two [Is Fold (b)(6)] and a tele wanted to return to 8/29/24 at 12:30 P Resident #1 being the elevator with [Is Fold (b)(6)] resident was being [Is Fold (b)(6)]. The facility's failure including the levator with [Is Fold (b)(6)] the use of [Is Fold (b)(6)] Exec Oresulted in an Imm The IJ began on 8/0bserved in the [Is Fold (b)(6)].	de to ensure all residents were 26.4b1 for the purposes of NJ Exec Order 26.4b1 at practice was identified for 1 #1). dmitted to the facility, and was 26.4b1 Resident #1 was resident #1 was not permitted oup activities and community 1 stated that they were not heir room; have visitors unless proved by the participate in heals in their room on not allowed use the telephone; which the resident reported der 26.4b1 being in a room and day seven days a week with evision. Resident #1 stated they on the participate in a wheelchair to S FOIA (b)(6), and the NJ Exec Order 26.4b1 The to ensure all residents, were free from posed a likelihood to order 26.4b1 posed a likelihood to order 26.4b1 posed a likelihood to	F 6	30th, 2024 the facility discontinu contracts with all NJ Ex Order 26.4 will no longer accept any NJ Ex Order 26	t(b)(1) and er 26.4(b)(1) and		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		315124	B. WING _				-C 30/2024
	ROVIDER OR SUPPLIER	ABILITATION CENTER		439	REET ADDRESS, CITY, STATE, ZIP CODE 9 BELLEVUE AVENUE RENTON, NJ 08618	<u>1 001</u>	00/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 604	Continued From page	e 56	F	504			
	PM. The survey team	Plan (RR) on 8/30/24 at 1:44 verified the implementation during the continuation of 8/30/24.					
	The findings were as	follows:					
	Surveyors on Federa services to Justice In 12/23/2016 S & C 16 Nursing Facilities mu autonomy and choice practicable regarding	MS) updated Guideline to I Requirements for Providing volved individuals, revised -21-ALL documented Skilled st permit residents to have to the maximum extent how they wish to live their eceive care with the same					
	revised 1/3/24, include treated equally regard religion, culture, lang disability, socioecond orientation, or gended expressionResidenthe right to be treated including: the right to	t Rights:5. the resident has I with respect and dignity be free from physical or nposed for the purpose of					
	dated revised June 2 of [facility] to not tolel abuse, neglect, or ex volunteers, visitors or another resident. The prevention program to physical and mental and series of the series o	y's "Abuse Prevention" policy 024, included it is the policy rate any form of resident ploitation by staff members, family members, or by a facility will have an abuse that protects residents from abuse [] in compliance with gulationsInvoluntary					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245404				R-C	
NAME OF D	ROVIDER OR SUPPLIER	315124	B. WING _	STREET ADDRESS, CITY	Y STATE ZID CODE	08/30/2024	
NAME OF P	ROVIDER OR SUPPLIER			439 BELLEVUE AVENU			
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER		TRENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	ER'S PLAN OF CORRECTION REECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFICIENCY)	D 4.T.E	TION
F 604	seclusion: the separaresidents or from his/his/her room against will of the responsible Rights: as a nursing New Jersey, you hav Freedom from Abuse physical and mental achemical and physical and mental achemical and physical authorized by a physitime to protect you or injury A review of the facility Programs Manual Todated effective Octobwill be used only whe symptoms and not us The least restrictive reduration of time will be resident in reaching that and psychosocial we but are not limited to [] leg restraintsGuplan to ensure that reinterventions have be consideration of the rephysician's order for Physical Restraint Infresident or responsibility revise the following: to the	tion of a resident from other her room, or confinement to resident's will or against the a partyResident Bill of nome resident in the State of the the following rights:[] and Restraints: free from abuse; freedom from all restraints, unless they are ician for a limited period of the others from physical of the restraint Management of the state of the abuse; freedom from physical of the restraint for the shortest of the straint alternative of the straint alternative of the straint fine shortest of the straint fine of the shortest of	F	504			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		ONSTRUCTION	· '	E SURVEY IPLETED
							R-C
		315124	B. WING			08	3/30/2024
NAME OF P	ROVIDER OR SUPPLIER		•	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER			BELLEVUE AVENUE		
				TRE	ENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 604	needed to don (wear, surveyor asked if stat resident was out of the Supervisor #1 stated who remained in their unless to go to unless that they and the At that time, the surve #1, who stated they had at the that they wanted to read and unless to order 26.4b they remained in their day, seven days a we television. Resident # room on disposable wactivities. Resident # prohibited visitors unless and the unless to complain about received, and the unless to could have their week stated the use folkality in the phone calls, and the unless to request to request to the unless to the unless to request to request to request to request to request to request to the unless to request to reques	aff provided care, they additional PPE. The fi had to wear PPE when the fine room, and the LPN that [Resident #1] was a with the least of the least	F	604			
	anytime they received						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		315124	B. WING			R-C
NAME OF P	ROVIDER OR SUPPLIER	313124		STREET ADDRESS, CITY, STATE, ZIP CO		8/30/2024
		REHABILITATION CENTER		439 BELLEVUE AVENUE TRENTON, NJ 08618		
	I					
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 604	were present they went to	nage 59 nad visitors or made a call, the t. Resident #1 stated that when they wore an NJ Exec Order 26.4b1 them because it let ey were a NJ Exec Order 26.4b1 them because it let and the NJ Exec Order 26.4b1	F (504		
) in resident stated, "n	the room or in the same and the o", they were order 26.461. interview, the surveyor asked				
	accurate, and the was NJ Exec Order 26.4b1	g the resident reported was stated "yes", the resident				
	the medical record	41 AM, the surveyor reviewed d for Resident #1.				
	admission summa was admitted to the	mission Record face sheet (an arry) reflected that the resident the facility with diagnoses which mited to; NJ Exec Order 26.451				
	Nursing Note date included the resid on MIEXEC OTHER 2 at 6:55	ogress Notes included a additional additional additional at 7:37 AM, which ent was admitted to the facility if PM, accompanied by US FOIA (D)(6) admitted with a NU Excelorate 26.451				
	Data Set (MDS), a	ost recent quarterly Minimum an assessment tool dated the resident had a brief				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SI COMPLE	
		315124	B. WING _			R-C) 0/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	1 00/30	0/2024
BELLE C	ARE NURSING AND REH	IARII ITATION CENTER		439 BELLEVUE AVENUE			
BELLE CA	THE NORSING AND REP	IABILITATION CENTER		TRENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A: CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA		(X5) COMPLETION DATE
F 604	Continued From page	e 60	F 6	604			
	interview for mental sindicating that the res	status score of the out of 15, sident had an the certain sident had an the resident					
		dual comprehensive care the following focus areas:					
	the not the staff to was not permitted to facility unless NJ Ex	cess to telephones, not nes. In the state of it. The resident go out on pass or out of the tec Order 26.4b1 by tion was that the resident					
	than water pitcher (w	oe no food or drinks other then clinically approved) to . The intervention included Exec Order 26.4b1					
	Interventions include as ordered; monitor, needed any signs an	revealed the resident NJ Exec Order 26.4b1. d to administer medications document, and report as d symptoms of NJ Exec Order 26.4b1 and report to physician as Order 26.4b1					
	Note dated NJ Exec resident reported NJ Exec	ec Order 26.4b1 <mark>"</mark> and felt at times. The resident					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		DNSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245424	B. WING				1-C
NAME OF D		315124	B. WING_	OTD	FET ADDRESS SITV STATE ZID SODE	08	30/2024
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER			BELLEVUE AVENUE ENTON, NJ 08618		
0.0.15	CUMMADVCT	ATEMENT OF DEFICIENCIES			·		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 604	Continued From page	e 61	F 6	604			
	today for a follow-up	c Order 26.4b1 visit dated the resident was seen visit. The resident reported treported feeling at times with					
	A review of the Order following physician's	Listing Report included the orders (PO):					
		that the resident unless NExec Order 25.461 unless NExec Order 25.4 acy Medical Services (EMS).					
	the US FOIA (b) (6 Resident #1 participa NJ Exec Order 26.4b1 times a v stated that [Res the NJ Exec Order 26.4b1 the not NJ Exec Order 26.4b1 The #1 was NJ Exec Order and use the NJ US FOIA (1) stated that [Res NJ Exec Order 26.4b1 that their and use the NJ US FOIA (1) stated that [Res NJ Exec Order 26.4b1 that their and use the NJ	ted in NJ Exec Order 26.4b1 veek in the NJ Exec Order 26.4b1 veek in the NJ Exec Order 26.4b1 who always remained were no other residents ated that [Resident #1] did refer 26.4b1 because they not stated that Resident refer 26.4b1) and not stated that Resident refer 26.4b1. The ident #1] was currently 1.4b1 the NJ Exec Order 26.4b1 tree NJ Exec Order 26.4b1					
	the LPN #1 in the pre	PM, the surveyor interviewed sence of LPN #2, who #1] received NJEXEC OTGET 26.450 for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315124	B. WING			R-C	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 439 BELLEVUE AVENUE TRENTON, NJ 08618		8/30/2024	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 604	a NJ Exec Order Was the National Resident #1] saw facility because the NJ Exec Order 26.4b1 The always US FOIA the only time [Resident #1] and doctor asked how often to appointments, and unsure if there was [Resident #1] had LPN #2 stated that transportation, an [Resident #1] to a On 8/29/24 at 12: Resident #1] to a On 8/29/24 at 12: Resident #1 sitting NJ Exec Order 26.4b1 he surveyor they were going, at the NJ Exec Order 26.4b1 he surveyor they were going.	LPN #1 stated the LPN #1 stated the was a set schedule, but that an appointment but the LPN #2 stated she was a set schedule, but that an appointment "LIVE Set LPN #3 setup the did the LPN #4 stated she was a set schedule, but that an appointment companied and from the appointment.	F	504			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
						R	-C
		315124	B. WING			08/	30/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 39 BELLEVUE AVENUE RENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 604	A review of the Order include a PO for the include a 12:56 Ft the US FOIA (b)(6) That she had started a the previous owners owith the include a previous owners owith the include and when their medic the include and when their medic the include and went to that [Resident #1] start include and went to them. The include and went to them. The include and went to them. The include and went to the include a point include and went to the include a point include a	PM, the surveyor continued record. Listing Report did not NJ Exec Order 26.4b1 did include a focus area for who stated at the NJ Exec Order 26.4b1, and of the facility had a contract of the facility had a contract of the facility for medical services, all treatment was completed, the NJ Exec Order 26.4b1 stated yed in their room with the accompanied by the NJ Exec Order 26.4b1 stated that (Resident #1] 4b1 as "NJ Exec Order 26.4b1" by the NJ Exec Order 26.4b1" by the NJ Exec Order 26.4b1 that. The USFOAL stated it was ity staff using the NJ Exec Order 26.4b1 the facility was in control of the facility was in control of the g care, and everything else not the facility, they just did	F	604			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		315124	B. WING		R-C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	08/30/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 604	1:44 PM indicated the to NJ Exec Order The facil action plan to remedicincluding the resident the facility ended to accept to accept were inserviced memo regarding responsible for the impolicies and regulation.	wal Plan (RP) on 8/30/24 at a caction the facility will take 26.4b1 ity implemented a corrective ate the deficient practice to the state of the contract with the has no other contracts with the has no other contracts with the regarding CMS's S & C and the state of all facility ins. fied the implementation of the 0/24.	F 6	04	
F 679 SS=E	Activities Meet Interec CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The factor of the comprehensive at and the preferences of program to support reactivities, both facility individual activities are designed to meet the physical, mental, and each resident, encourand interaction in the This REQUIREMENT by: Based on observation	cility must provide, based on ssessment and care plan of each resident, an ongoing esidents in their choice of sponsored group and independent activities, interests of and support the psychosocial well-being of raging both independence	F 6	Resident #1 was immediately discharged from the facility. On A	, I

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245404	B WING			R-C	
		315124	B. WING _			08/	30/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BELLE CA	ARE NURSING AND REH	IABII ITATION CENTER		43	9 BELLEVUE AVENUE		
DLLLL OF	THE HOROMO AND INEM	ADIENATION SERVER		TF	RENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 679		to ensure a NJ Exec Order 26.4b1	F 6	679	30th, 2024 the facility discontinued		
	activities of their choi interests of and supp	rovided since admission ce designed to meet the ort the NJ Exec Order 26.4b1 of each resident,			contracts with all NJ Ex Order 26.4(b)(1) will no longer accept any NJ Ex Order 26.4(b)	(1)	
	0 0	ependence and interaction			All Justice involved Residents hav	е	
		is deficient practice was			the potential to be affected by this		
	identified for 1 of 1	(Resident #1) reviewed.			deficient practice.¿		
	The findings were as	follows:			3. On 8/30/2024 the Clinical VP of Operations conducted in-service education with all administrative staff o	n	
	Reference: The Cent	ers for Medicare and			the importance of providing residents v	/ith	
	Medicaid Services (C	MS) updated Guideline to			a meaningful group and individualized		
	Surveyors on Federa	I Requirements for Providing			activity program that reflects their		
	services to Justice In	volved individuals, revised			preferences.¿		
	12/23/2016 S & C 16	-21-ALL documented Skilled			4. The Administrator/designee will au	dit	
	_	st permit residents to have			5 residents a month x 4 months to ensi	ıre	
		e to the maximum extent			that residents are provided with a		
		how they wish to live their			meaningful group and individualized		
		eceive care with the same			activity program that reflects their		
	rights as nursing hom	ne residents.			preferences. Audit findings will be shar with the QAPI committee monthly x 4	ed	
	revised 1/3/24, includ	y's "Resident Rights" dated led 10. all residents will be			months.¿		
		dless of age, race, ethnicity,					
		uage, physical or mental					
	-	omic status, sex, sexual					
	orientation, or gender						
		t Rights: 1. the resident has					
	the right to a dignified	nd communication with and					
	'						
	-	nd services inside and					
		the resident has the right to					
		ct and dignity including: the					
	right to be free from p	-					
		r the purpose of discipline or					
		right to retain and use					
	services in the facility	s [] the right to receive					
	. 30171003 111 1110 14111117	will leasulable	1	- 1			

OLIVILIV	O T OIT MEDIONITE &	WEDIO/ ND OEI WIOLO				OWID IT	0. 0000 0001		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
						F	R-C		
		315124	B. WING			80	3/30/2024		
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		43	TREET ADDRESS, CITY, STATE, ZIP CODE 39 BELLEVUE AVENUE RENTON, NJ 08618				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 679	roommate of his/her Self-determination: the and the facility must president self-determineresident choice include choose activities, softheir interests; the rig aspects of his or her resident; interact with community; receive with time of their choose activities including so community activities. confidentiality: the repersonal privacy and personal and medical environment: the resiclean, comfortable and A review of the facility reviewed 5/1/24, incluprograms are designed to encourage individualized to meet of Resident #1's roominterviewed the Licens Supervisor (LPN Supervisor (LPN Supervisor interviewed to include in the self-determination.)	sident needs and ght to share a room with a choice [] 6. he resident has the right to promote and facilitate hation through support of ding but not limited to; [] hedules [] consistent with the make choices about life that are significant to the members of the risitors of their choosing at singparticipate in other hocial, religious, and	F	679					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING			R-C		
NAME OF P	ROVIDER OR SUPPLIER	313124	B. Willo	STREET ADDRESS, CIT	Y STATE ZIP CODE	08/	30/2024	
				439 BELLEVUE AVENU				
BELLE CARE NURSING AND REHABILITATION CENTER				TRENTON, NJ 0861	18			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COI	DER'S PLAN OF CORRECTION PRRECTIVE ACTION SHOULD E FERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 679	needed to don (weasurveyor asked if st resident was out of Supervisor #1 state NJ Exec Order Their room unless to LPN St the resident did not their meals in their needed to be schedappointment; and the Market Wille William (with the Market William) with the Market William (with the Market William) who surveyor interviewe they had been at the and they were receit the facility. Residen return to the NJ Exus FOIA (b)(6) they remained in the day, seven days a way television. The resident of the day, seven days a way television. The resident of the day, seven days a way television. The resident of the day, seven days a way television. The resident of the day, seven days a way television. The resident of the day, seven days a way television. The resident of the day, seven days a way television. The resident of the day, seven days a way television. The resident of the day, seven days a way television. The resident of the day, seven days a way television to the day, seven days a way television. The resident of the day, seven days a way television to complain about the day of the	arr) additional PPE. The aff had to wear PPE when the the room, and LPN d that Resident #1 was a 26.4b1 who remained in go to the supervisor #1 continued that participate in activities; ate all room on disposable ware; visitors where the surveyor observed bed with US FOIA (b)(6) AM, the surveyor observed bed with US FOIA (b)(6) AM, the surveyor observed bed with US FOIA (b)(6) Were on their cell phones dent's door strength and the strength and the facility of and the facility of and strength and strength and a strength and the strength and a strength and the strength and the strength and the strength and a strength and the strength and the strength and a strength and the strength and the strength and a strength and there were no strength and the strength and a strength and there were no strength and the strength and the strength and a strength and the strength and a strength and there were no strength and the strength and the strength and a strength and the	F	579				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION ILDING		
	315124	B. WING _			l	-C 30/2024
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	1 00/	30/2024
			439 BELLEVUE AVENUE			
BELLE CARE NURSING AND R	EHABILITATION CENTER		TRENTON, NJ 08618			
PREFIX (EACH DEFICIE	'STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA		(X5) COMPLETION DATE
twice a month, so phone calls, and the phone calls, and the to request to request anytime they recei room, and if they have present they went to were present they went to everyone know the asked if the reside in the root stated, no, NJ Executed the resident stated were supposed to. At the time of the inference asked if everything accurate, and the was NJ Executed the medical record. A review of the Adiadmission summan was admitted to the included but not limited. A review of the Pro Nursing Note date included the reside on NJ Executed.	maybe came to the facility they missed their allowed he resident wanted to call their to be NJ Exec Order 26.4b1 to the tated they had NJ Exec Order 26.4b1, wed care the lad visitors or made a call,	F	679			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		315124	B. WING			R-C 08/30/2024
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 439 BELLEVUE AVENUE TRENTON, NJ 08618		3070072024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 679	Data Set (MDS), an reflected the interview for mental which indicated a limit of the individual of the	t recent quarterly Minimum assessment tool dated e resident had a brief status score of status score of out of 15, weekly Exec Order 26.4b1. Tidual comprehensive care de the following focus areas: The tresident was not landlines e land to the facility unless of the facilit	F 6	79		
	activities.	clude a focus area for				
	the facility's US FOIA wh	AM, the surveyor interviewed o stated she had just started				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			R-C 08/30/2024		
	ROVIDER OR SUPPLIER ARE NURSING AND F	EHABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP C 439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIAT		(X5) COMPLETION DATE	
F 679	on 8/29/24 at 11:5 the US FOIA (b) were conducted in and staff did needed. The providing puzzles surveyor asked if Resident #1, and did not see them that there were not really suppose not provide any acgames. The stranger cafacility was not allow had to provide. On 8/29/24 at 12:3 Resident #1 sitting transported down in an NJ Exec Order 26. resident if they even they were going, at the NJ Exec Order 26. resident if they even they requested, ar On 8/29/24 at 12:5 On 8/29/24 at 12:5 In the previous owner they requested, ar on 8/29/24 at 12:5 On 8/29/24 at 12:5 In the previous owner they requested on the previous owner they were going. They were going at the NJ Exec Order 26. They were going at the previous owner they requested, ar on 8/29/24 at 12:5 On 8/29/24 at 12:5 In the previous owner they requested at 12:5 They were going at the previous owner they requested, ar on 8/29/24 at 12:5 They were going at the previous owner they requested at 12:5 They were going at 12:5 Th	sidents yet. The surveyor asked ith Resident #1, and she stated it was on her list. 55 AM, the surveyor interviewed (6)) who stated activities a groups on both nursing units, xec Order 26.4b1 as tated that Surveyor dealer 26.4b1 included and crossword puzzles. The she provided Stated that activity staff that often. The stated that activity staff that often in there; that she could stivities, crossword puzzles, or ated the resident requested a rds about a staff was ago, and the owed to provide, that the	F	679				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COMP	SURVEY LETED
		315124	B. WING			1	-C 30/2024
NAME OF PROVIDER OR S		ABILITATION CENTER	,	4:	TREET ADDRESS, CITY, STATE, ZIP CODE 39 BELLEVUE AVENUE TRENTON, NJ 08618		<u> </u>
PREFIX (EAC	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
At that time informed to visits, and unless the were no pure the resolution of the transporta scheduled Resident all the other not have to facility was care, and unless the scheduled Resident all the other not have to facility was care, and unless the scheduled Resident all the other not have to facility was care, and unless the scheduled Resident all the other not have to facility was care, and unless the scheduled Resident all the other not have to facility was care, and unless the scheduled Resident all the other not have to facility was care, and unless the scheduled Resident all the other not have to facility was care, and unless the scheduled Resident's on 8/29/2 survey teams.	their mediceturned to the turned that the factor of the turned to turned to the turned to the turned to the turned to the turned to turned to the turned to turn	refacility for medical services, cal treatment was completed, the services. The services continued accompanied by them. It everything was controlled cility could not provide usage; visitors. The service to the facility she in for the resident to make a id not believe there was a service to the facility she in for the resident to make a id not believe there was a service to the facility she in for the resident to make a id not believe there was a service to the facility she in for the resident to make a id not believe there was a service to the facility she in for the resident to make a id not believe there was a stated that the resident to the facility she in for the resident to make a service that the resident to the without them. The resident in the elevator during the resident saw an outside appointments were	F	679			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		315124	B. WING		1	-C 30/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 679	Continued From page	e 72	F 67	79			
	No additional informa	tion was provided.					
{F 835} SS=J	NJAC 8:39-7.3(a) Administration CFR(s): 483.70		{F 83	5}		9/18/24	
	enables it to use its refficiently to attain or practicable physical, well-being of each re This REQUIREMENT by: Based on observation pertinent facility document the facility US Facility implemented processigned an Admission admission to the faciliautonomy to participal community dining, semanner, freely community dining, semanne	ministered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. T is not met as evidenced on, interviews, and review of ments, it was determined old (b)(6) failed to a.) ensure the policies and procedures for Self Determination as well dures to prevent b.) ensure residents Agreements upon ity; c.) were afforded the late in group activities, arving meals in a dignified unicate with visitors, and to and d.) ensure facility policies 26.4b1 were in eand Federal regulations. It was identified for 1 of 1		1. Resident #1 was immediately discharged from the facility. On Augu 30th, 2024 the facility discontinued contracts with all NJ Ex Order 26.4(b)(1 will no longer accept any NJ Ex Order 26.4 (b)(1 will no longer accept any NJ Ex Order 26.4 (b)(1 will no longer accept any NJ Ex Order 26.4 (b)(1 will no longer accept any NJ Ex Order 26.4 (b)(1 will no longer accept any NJ Ex Order 26.4 (c) 3. On 8/30/2024 the Clinical VP of Operations conducted in-service education with all administrative staff the importance ensuring that policies procedures are being followed for rerights and self-determination, preven physical restraints and seclusion, admission agreements are being sig upon admission, residents are afford autonomy to participate in group acticommunity dining, serving meals in a dignified manner, freely communicativisitors, and to leave room at will. ¿	and (b)(1) ave fon and sident t ned ed vities, a e with		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING R-C B. WING STREET ADDRESS, CITY, STATE, ZIP CODE	ETED
315124 B. WING 08/30/	
1 00/30/	<u>0/2024</u>
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BELLE CARE NURSING AND REHABILITATION CENTER 439 BELLEVUE AVENUE TRENTON, NJ 08618	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
but not limited to: NJ Exec Order 26.4b1 reported to the surveyor on that they had been at the facility were that they were not allowed to leave their room; have visitors unless scheduled and approved by the could not choose their described at television. Resident #1 stated that they were not allowed use the telephone; and had in the limited at television. Resident #1 stated that they were not allowed to leave their room; have visitors unless scheduled and approved by the could not choose their promises and their room on disposable ware; not allowed use the telephone; and had in their room on disposable ware; not allowed use the telephone; and had in the limited that they were not allowed use the telephone; and had in the limited that the limited to attempt the limited to attempt the limited to the limited to attempt the limited to a television. Resident #1 stated they wanted to the limited that the limited that they were not allowed use the telephone; and had in the limited to the limited that the limited to a television. Resident #1 stated they wanted to the limited that the limited to the limited to the limited to the limited that the limited that the limited to the limited that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	COI	(X3) DATE SURVEY COMPLETED	
		315124	B. WING		I	R-C 8/30/2024	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 439 BELLEVUE AVENUE TRENTON, NJ 08618		0/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{F 835}	This resulted in four after Reside facility and US FOI fifth IJ situation was PM, when Resident Administration was rat 4:29 PM. The faci Removal Plan (RP) survey team verified	IJ situations that began on ent #1 was admitted to the A (b)(6) and a at 12:30 #1 was NJ Exec Order 26.4b1 . The facility notified of the IJs on NJ Exec Order 26.4b1 . The facility submitted an acceptable on 8/30/24 at 1:44 PM. The the implementation of the gather continuation of the	{F 83	5}			
	Medicaid Services (C Surveyors on Federa services to Justice Ir 12/23/2016, S & C 1 Nursing Facilities mu autonomy and choic practicable regarding everyday lives and re rights as nursing hor A review of the facility revised 1/3/24, inclu- admission, the social inform the resident a representative of the responsibilities10. equally regardless of culture, language, pl	ters for Medicare and CMS) updated Guideline to al Requirements for Providing avolved individuals, revised 6-21-ALL documented Skilled ust permit residents to have to the maximum extent ghow they wish to live their eceive care with the same me residents. Ly's "Resident Rights" dated ded 1. prior to or upon I service designee [] will					

OL. TILIT	S I S I I II E BIOT II LE G	INEDIO/ (ID CEITTICE)					3. 0000 000 1
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		SURVEY PLETED
						R	r-C
		315124	B. WING				/30/2024
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
DELLE OA	DE MUDOINO AND DEU	A DIL ITATION OF NITED		4	439 BELLEVUE AVENUE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER		1	TRENTON, NJ 08618		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION DATE
					DEFICIENCY		
(E 025)	Continued Frame man	- 75	(F.				
{F 835}	Continued From page		{F 8	335}	†		
	, .	pressionResident Rights: 1.					
		ight to a dignified existence,					
		nd communication with and					
	access to persons an						
		the resident has the right to					
	right to be free from p	ct and dignity including: the					
		r the purpose of discipline or					
		right to retain and use					
		s [] the right to receive					
	services in the facility	-					
	accommodation of re						
		ght to share a room with a					
	roommate of his/her						
		ie resident has the right to					
	and the facility must p						
		nation through support of					
	resident choice includ	ling but not limited to; []					
	choose activities, sch	edules [] consistent with					
	their interests; the rig	ht to make choices about					
	aspects of his or her	life that are significant to the					
	resident; interact with						
	-	isitors of their choosing at					
		singparticipate in other					
	activities including so	-					
	community activities.						
	confidentiality: the res						
		confidentiality of their					
	personal and medica	dent has the right to a safe,					
	clean, comfortable ar	•					
	,	evances: the resident has					
		vances to the facility [] the					
		ompt efforts by the facility to					
	resolve grievances th						
	1.000110 griovarious tri	o recident may have.					
	A review of the facility's "Abuse Prevention" policy						
	-	024, included it is the policy					
		rate any form of resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		DENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED	
		315124	B. WING _			R-C 08/30/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND R	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE	00/30/2024	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
{F 835}	volunteers, visitors another resident. I prevention prograr physical and ment State and Federal seclusion: the sepresidents or from his/her room agair will of the responsi Rights: as a nursir New Jersey, you heredom from Abuphysical and ment chemical and physical and programs Manual dated effective Oc will be used only with symptoms and not the least restrictive duration of time with resident in reaching and psychosocial with the physical restraints plan to ensure that interventions have consideration of the physical Restraint resident or respon revise the following	exploitation by staff members, or family members, or by The facility will have an abuse in that protects residents from all abuse [] in compliance with regulationsInvoluntary faration of a resident from other his/her room, or confinement to list resident's will or against the lible partyResident Bill of light for a gainst the following rights: [] are and Restraints: free from all abuse; freedom from sical restraints, unless they are hysician for a limited period of light or others from physical for or others from physical for a staff convenience. The applied to assist the general the shortest lible applied to assist the general for the shortest lible applied to assist the general for the shortest lible applied to assist the general form the shortest lible applied to assist the general form the shortest lible applied to assist the general form the shortest lible applied to assist the general form the shortest lible applied to assist the general form the shortest lible applied to assist the general form the shortest lible applied to assist the general form the shortest lible applied to assist the general form the shortest lible applied to assist the general form the shortest lible applied to the following: arm restraints Guidelines: 1. evaluate care the restraint alternative lible period to the sible party [] 5. provide the linformation Sheet to the sible party [] 6. review and	{F 8	35}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		315124	B. WING			R-C 08/30/2024
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 439 BELLEVUE AVENUE TRENTON, NJ 08618	P CODE	00/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
{F 835}	residents to receive resident's wishes an of other residents in contact with the comor is familiar. Proced may visit the resider protection of the right residents and any resident5. resident the clergy at any time the rights of others coutbreaks A review of the facility reviewed 5/1/24, incorporams are designed to encoura individualized to me. A review of the Adm provided by the facility accountable for all a [name redacted] sub promulgated by gov proper health care is Administrator admin coordinates all active that the highest deg provided to the resident modern and the resident active that the highest deg provided to the resident active that the highest deg provided to implement and the resident active that the resident active that the resident active that the highest deg provided to the resident active that the resident active the resident active that the resident active that the resident active that the resident active the resident ac	included the facility permits visitors subject to the ad the protection of the rights the facility to maintain inmunity in which he/she lived dure: 1. the resident's family in at any time subject to the ats and safety of other estrictions imposed by the its may visit with members of the subject to the protection of during communicable disease of the available on a daily activity programs are age participation and are et each resident's needs inistrator's job description into the facility revealed the following: consible for planning and is activities and departments at object to rules and regulations to rules and regulations ernment agencies to ensure ervices to residents. The isters, directs, and ities of the facility to assure are of care is constantly dents countabilities included but not its [name redacted] objectives	{F 8	335}		
		directed by the governing ctices within guidelines and				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION NG	(X3	3) DATE SURVEY COMPLETED	
		315124	B. WING _			R-C 08/30/2024	
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	1
{F 835}	concerns his/hersel facility residents in of for fire and accident department manage use of departmenta ensure that resident highest level of servicompassionate atm individuals needs at On 8/29/24 at 9:45 apersonal protective of Resident #1's roci interviewed the Lice Supervisor (LPN Su [Resident #1] had a nd when so needed to don (wea surveyor asked if st resident was out of Supervisor #1 state who remained in the NJ Exec Order 26.4b1 #1 stated that [Resident was on the wisitors need the wisi	es as necessary; ral operations of the facility; f with the safety of all nursing order to minimize the potential se; oversees and guides res in the development and depolicies and procedures; and res and families receive the rice in a caring and resphere which recognizes the red rights AM, the surveyor observed a requipment (PPE) bin outside red and rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment (PPE) bin outside red rights AM, the surveyor observed a requipment receive the rice in a caring and respondence the rice in the receive the rice in a caring and respondence the rice in the receive the rice in the receive the rice in a caring and respondence the rice in a cari	{F 8	35}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTIO	N	(X3) DATE COMP	SURVEY
		045404	D WING			1	-C
		315124	B. WING _			08/	30/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP CODE		
BELLE CA	ARE NURSING AND REI	HABILITATION CENTER		439 BELLEVUE	AVENUE		
DLLLL CA	THE HUNSING AND INE	IABILITATION CENTER		TRENTON, NJ	08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD E S-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 835}	Resident #1 lying in who resident's door window were stated that they weekly grievance paperwork about it, which they weekly phone call. Resident wanted to compare they had stated that when an stated that when an NJ Exec Order sould because it let everyous the surveyor asked	bed with US FOIA (b)(6) were were and the resident's that time, the surveyor t #1, who stated they had J Exec Order 26.4b1, and they and were care at the stated that they wanted to y were cility because they remained four hours a day, seven days and a television. Resident their room on disposable to no activities. Resident #1 to prohibited visitors unless to visits, and the they were waiting for to from the was supposed to come so they could have their the facility twice a month, so to be dependent with the room of the care to room, and if they had visitors they were present. Resident they went to they ware a if Resident #1 had to in the room or in the room of the recover.	{F 8:				
	The surveyor asked	ted, "no", they NJ Exec Order 26.4b1 if the resident saw the esident #1 stated, "no", but ere supposed to.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
		315124	B. WING _			R-C 08/30/2024
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE	00/00/2024
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 835}	On 8/29/24 at 10:4 the medical record was admitted to the included but not line. A review of the Pr Nursing Note date included the resident was at 6:55. The resident was a first representation of the resident was a first resident was a fir	interview, the surveyor asked g the resident reported was stated "yes", the resident 11 AM, the surveyor reviewed of for Resident #1. In insision Record face sheet (an arry) reflected that the resident refacility with diagnoses which mitted to; In items and at 7:37 AM, which rent was admitted to the facility of PM, accompanied by admitted with a service of the resident had a brief all status score of the resident had an out of 15, resident had an output of 15, resident had an out	{F 8	35}		
		led the following focus areas:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING _ R-C 315124 B. WING 08/30/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **439 BELLEVUE AVENUE** BELLE CARE NURSING AND REHABILITATION CENTER TRENTON, NJ 08618 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {F 835} Continued From page 81 {F 835} was not permitted access to telephones, not landlines or cell phones. In the ' " when phone use was permitted, not the staff take care of it. The resident was not permitted to go out on pass or out of the facility unless NJ Exec Order 26.4b1 The intervention was that the resident would be NJ Exec Order 26.4b1 by the A focus area dated New Transfer indicated ' dining: there was to be no food or drinks other than water pitcher (when clinically approved) to be stored at bedside. The intervention included was the resident NJ Exec Order 26.4b1 and be NJ Exec Order 26.4b1 A focus area dated 8/11/24, revealed the resident other 28.4b1 with NJ Exec Order 26.4b1. Interventions included to administer medications as ordered; monitor, document, and report as needed any signs and symptoms of and monitor, record, and report to physician as NJ Exec Order 26.4b1 On 8/29/24 at 11:01 AM, the surveyor interviewed the US FOIA (b)(6)), who stated Resident #1 participated in NJ Exec Order 26 US FOIA (b) (6) times a week in the NJ Ex Order 28.4(b)(1) The stated that [Resident #1] was transferred to by two ^{US FOIA III} who always remained with them, and there were no other residents present. The stated that [Resident #1] did NJ Exec Order 26.4b1 The stated that Resident #1 was working or NJ Exec Order 26.4b1 and that their NJ Exec Order 26.4b1 and use the NJ Exec Order 26.4b1. The stated that [Resident #1] was currently NJ Exec Order 26.4b1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		315124	B. WING				-C
	201/1252 02 01/221/152	315124	B. WING			08/	30/2024
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER			439 BELLEVUE AVENUE		
		-			TRENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 835}	Continued From page	e 82	{F 8	35	}		
,		the NJ Exec Order 26.4b1	, ,	,,,,			
	could not NJ Exec Order 26.4b1	; that the facility					
		AM, the surveyor interviewed stated she had just started					
	at the facility NJ Exec Order 26.	and had not gotten to					
		ents yet. The surveyor asked					
		Resident #1, and she stated					
	"no", but the resident	was on her list.					
	On 8/29/24 at 11:55 A	AM, the surveyor interviewed					
	the US FOIA (b)(6) who stated activities					
		oups on both nursing units,					
	and staff did NJ Exe	c Order 26.4b1 as					
		ed that activities included					
		d crossword puzzles. The					
	surveyor asked if she	provided activities for stated that activity staff					
		#1] that often. The					
		e US FOIA (b)(6) in there and staff					
		sed to be in there; that she					
	could not provide any						
		he stated that [Resident					
	#1] requested a pack	of playing cards about a					
	ago, and the fa	acility was not allowed to					
	provide, that the USFOI	had to provide.					
		PM, the surveyor interviewed					
	Resident #1's assign	ed CNA (CNA #1), who					
	stated that [Resident	#1] NJ Exec Order 26.4b1 care;					
	that they were able to						
	permitted out of their	, and the resident was room to the shower room					
		d the CNA provided the					
	washcloth and towel.						
		it was just the resident in					
	the room with the USFO	OIA (b)(6). CNA #1 stated that					
		ate all their meals in their					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	COMPI	
						R.	-C
		315124	B. WING	_		08/	30/2024
	ROVIDER OR SUPPLIER RE NURSING AND REH	ABILITATION CENTER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 835}	the NJ Exec Order the resident saw a NJ Exec Order 26.4b1. The LF always US FOIA (b)(6) only time [Resident # NJ Exec Order 26.4b1]. The LF always and doctor's ap asked how often [Res appointments, and the unsure if there was a [Resident #1] had an LPN #2 stated that the transportation, and th [Resident #1] to and f On 8/29/24 at 12:30 F Resident #1 sitting in transported down the he surveyor as they were going, and the NJ Exec Order 26.4b1, tha appointment was at th NJ Exec Order 26.4b1 Resident #1 if they ev they requested, and F surveyor then observe	PM, the surveyor interviewed sence of LPN #2, who #1] received to see the facility's PN #1 stated that there were with the resident, and the filler their room was for pointments. The surveyor sident #1] had NJ Exec Order 26.4b1 accompanied from the appointment. PM, the surveyor observed a wheelchair being the facility being the hospital, and that their he hospital, and that their the hospital, and that their the decreased that their the decreased that their the hospital, and that their the decreased that their the decreased that their the decreased that their the hospital that their the hospital that their the decreased that their the decreased that their the hospital that their the hospital that their the decreased that the filler that their the decreased that the filler that their the hospital that their the decreased that the filler that the fill	{F &	335)			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING _ R-C 315124 R WING 08/30/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **439 BELLEVUE AVENUE** BELLE CARE NURSING AND REHABILITATION CENTER TRENTON, NJ 08618 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {F 835} Continued From page 84 {F 835} At that time, the surveyor asked [Resident #1]NJ Exec Order 26.4b since it was reported earlier that [Resident #1] did not need because NJ Exec Order 26.4b1 when the stated it was ' left the building. The surveyor asked how [Resident #1] was transferred to the hospital, and the stated on a medical bus from the The surveyor observed Resident #1 being out of the building by US FOIA (b On 8/29/24 at 12:56 PM, the surveyor interviewed in the presence of the userial who stated that she had started at the facility on the previous owners of the facility had a contract with the NJ Exec Order 26.4b1. The USFOIA DAY stated that the were only at the facility for medical services, and when their medical treatment was completed, returned to the The stated that Resident #1 stayed in their room with the two and went to NEXORE accompanied by them. stated that everything was controlled that the facility could not provide by the playing cards; phone usage; visitors. The stated the US FOIA (b)(6) came to the facility she thought once a month for the resident to make a phone call, but she did not believe there was a set schedule. At that time, the stated that [Resident #1] informed the facility that the had to approve all visits, and [Resident #1] could not have a visitor approved it. The stated there unless the were no private visits, that there were always and [Resident #1] could not be without them. The stated it was the policies; and Resident #1 could have NJ Exec Orde except their NJ Exec Order 26.4b1 " The

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONS	STRUCTION		SURVEY PLETED
							R-C
		315124	B. WING _			08	/30/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET	FADDRESS, CITY, STATE, ZIP CODE		
BELLE CA	ARE NURSING AND REH	IARII ITATION CENTER		439 BE	LLEVUE AVENUE		
DLLLL CA	AND NORSING AND INCI	ABIETATION CENTER		TRENT	ΓON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 835}	stated only [Resident the elevator during translated that the elevator during translated that [Resident #1] saw and the appointments we stated that [Resident #1] say and the appointments we stated that [Resident #1] say all the other they just did not have stated that [Resident #1] stated that [Resident	could be in ansportation, and that NJ Exec Order 26.4b1 that re scheduled by the sident #1] saw the facility's ed and could have seen the but will be a could have seen the facility. The street order 26.4b1 The street order 26.4b1 that was a will be control of that the facility was in the facility was in the facility was in the facility was in the facility of the resident's that was a will be copy or will	{F 8	35}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		DNSTRUCTION		PLETED
		315124	B. WING				-C 30/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REI	HABILITATION CENTER		439	EET ADDRESS, CITY, STATE, ZIP CODE BELLEVUE AVENUE ENTON, NJ 08618	1 00/	30/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 835}	permitted to access cell phones; 2. the lathe inmate room prion not to facilitate or pato use a telephone; 4 telephone use is per taken care of by the assigned COs; 5. at participate in inmate A review of the "Con Officers" policy dates should be treated wistaff On 8/29/24 at 2:52 F signed copy that Restheir "Resident Right asked where the copadmission, and why stated that the facility and identified received a copy of the Con 8/29/24 at 2:59 F surveyor with a copy Agreement" dated The Information acknowlessigned "Admission Admission.	inmates are not routinely telephones, not landlines or andline will be removed from or to admission; 3. the staff is ricipate in allowing inmates 4. in rare circumstances when mitted this will be entirely [CF staff], specifically the no time is [facility] staff to 's phone use. cerns with Correctional degree of the staff of the	{F 8	35}			
	survey team that she	PM, the second informed the had spoken to the to the facility who was permitted					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		NSTRUCTION		TE SURVEY MPLETED
		245424	P WING				R-C
		315124	B. WING _			0	8/30/2024
NAME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
BELLE CA	ARE NURSING AND REH	ABILITATION CENTER			BELLEVUE AVENUE		
		-		TRE	NTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 835}	Continued From page	e 87	{F 8	35}			
	to visit the resident a	nd when.					
	surveyor with a copy Agreement" dated	M, the of Resident #1's "Admission which was Network admitted to the facility.					
	stated their role as the ensure the safety of ras uphold facility polisurveyor asked the	M, the surveyor interviewed ence of the us FOIA (b)(6) and survey team, who e facility's us FOIA (b) (6) to residents and staff, as well cies and procedures. The if they reviewed CMS's ure the facility was up to					
	confirmed yes. An acceptable Remo 1:44 PM indicated the to NJ Exec Order The facil	val Plan (RP) on 8/30/24 at e action the facility will take					
	including the resident including the resident including the facility end including to accept including inc	t was returned to the on moded their contract with the has no other contracts with ept the their					
		fied the implementation of ring the continuation of the 0/24.					
	NJAC 8:39-4.1(a) NJAC 8:39-7.3(a)						

NAME OF PROVIDER OR SUPPLIER BELLE CARE NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618 (X5)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION G	(X3) DA	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER BELLE CARE NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) [F 835] Continued From page 88 NJAC 8:39-9.2(a) STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618 [CX5] PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE) [F 835] Continued From page 88 [F 835] Continued From page 88			0.45404				
BELLE CARE NURSING AND REHABILITATION CENTER #39 BELLEVUE AVENUE TRENTON, NJ 08618 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE CONTINUED FROM THE APPROPRIATE DEFICIENCY) F 835 NJAC 8:39-9.2(a)			315124	B. WING _			08/30/2024
TRENTON, NJ 08618 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) [EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) [F 835] Continued From page 88 [F 835] NJAC 8:39-9.2(a) [X5] PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	NAME OF PI	ROVIDER OR SUPPLIER					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) [F 835] Continued From page 88	BELLE CA	ARE NURSING AND REH	ARII ITATION CENTER		439 BELLEVUE AVENUE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) [F 835] Continued From page 88 NJAC 8:39-9.2(a)	DLLLL OF	AND INDINO AND INDI	ABILITATION CENTER		TRENTON, NJ 08618		
NJAC 8:39-9.2(a)	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE	COMPLETION
	{F 835}	NJAC 8:39-9.2(a)	e 88	{F 83			

		POST	-CERT	TFICATIO	N REVISIT R	EPORT	•		
PROVIDE	R / SUPPLIER / CLIA /	MULTIPLE CONS	STRUCTION					DATE OF RE	VISIT
IDENTIFIC	CATION NUMBER	A. Building							
315124	Y1	B. Wing					Y2	9/25/2024	Y3
NAME OF	FACILITY				STREET ADDRESS, CIT	TY, STATE, ZII	CODE		
BELLE C	ARE NURSING AND RE	HABILITATION C	ENTER		439 BELLEVUE AVENU	E			
					TRENTON, NJ 08618				
provision	d and the date such corre number and the identifice ey report form).								
ITE	M	DATE	ITEM		DATE	ITEM		D	ATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix	F0550	Correction	ID Prefix	F0557	Correction	ID Prefix	F0561	Со	rrection
	483.10(a)(1)(2)(b)(1)(2)	_		483.10(e)(2)			483.10(f)(1)-(3)(8)		
Reg. #		Completed	Reg. #		Completed	Reg. #		Co	mpleted
180		09/18/2024	1.00		00/18/2024	180		00/	18/2024

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		NSTRUCTION	1, ,	E SURVEY IPLETED
		315124	B. WING _			06	6/26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REF	IABILITATION CENTER	•	439 B	ET ADDRESS, CITY, STATE, ZIP CODE ELLEVUE AVENUE ITON, NJ 08618	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	3	K	000			
	New Jersey Departm Survey and Field Op 6/19/24, Belle Care I Center was found to the requirements for Medicare/Medicaid a Safety from Fire, and Protection Association	Survey was conducted by the tent of Health, Health Facility terations on 6/18/24 and Nursing And Rehabilitation be in noncompliance with participation in t 42 CFR 483.90(a), Life I the 2012 Edition of the Fire in (NFPA) 101, Life Safety 19 EXISTING Health Care					
	three-story, Type II of built in 1977. The fa zones. The building I houses: laundry, mai room and boiler roon sub-building spaces	are sprinklered parking tside. The building has a					
	powered generator, to lights, red outlets and	terior 85 KW natural gas hat does common space d 1 elevator, as per the r. The generator annunciator lurses station.					
K 281	occupying 94 resider		K	281			8/25/24
SS=F	Illumination of Means Illumination of means discharge, is arrange	s of Egress s of egress, including exit ed in accordance with 7.8 and uously in operation or					
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	•	TITLE		(X6) DATE
Electroni	cally Signed						07/24/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G 01		(X3) DATE SURVEY COMPLETED	
		315124	B. WING		06/26/2024		
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
K 281	intervention. 18.2.8, 19.2.8 This REQUIREMENT by: Based on observation in the presence of the it was determine exits in accordance we section 19.2.8 and 7 had the potential to a was evidenced by: An observation at 11: stairwell exit landing, had 2 ceiling mounternot operational. Cont several stair steps, et the parking area or of mounted light fixtures operational. In an interview at the confirmed the observation at 12: side stairwell exit bott mounted light fixtures operational. Leaving approximately 4 ft. by drive way, presented fixture that was not of ft. opening entering the servation in the confirmed that was not of ft. opening entering the servation in the confirmed that was not of the confirmed entering entering the confirmed entering ent	is not met as evidenced ns and interview on 6/19/24, EUS FOIA (b)(6) eed that the facility failed to means of egress to 2 of 5 with NFPA 101 2012 Edition, 8. This deficient practice ffect all 94 residents and 54 AM revealed the low side entering from the corridor, dight fixtures and both were inuing exit discharge down intering optional access to atside there were 2 ceiling and both were not US FOIA (b)(6) ations. 25 PM revealed the high tom landing had 2 ceiling and both were not	K 28	1. Two new ceiling mounted light: immediately installed on the low sic stairwell exit ending and in the area optional access to the parking area (see attached document labeled K 2. All residents are at risk to be a this practice. 3. U.S. FOIA (b) (6) will be in-serviced on ensuring all light fixts the facility are operational and in worder. 4. Maintenance director / Designee w all exit stairwells weekly for 4 week Monthly for 3 Months. Findings will submitted to the monthly QAPI comfor 3 months who will determine fur interventions as needed. Maintenance director / Designee w all facility lights including but not lin exit stairwells, exterior lighting, resi rooms, and day dining rooms, mont 4 months. Based on the result of the audit a decision will be made regard need for continued submission and reporting. All findings will be submitted.	le of of 281) ffected ures in orking fill audit s then be nmittee ther fill audit nited to dent hly for nese ling the		
	In an interview at the confirmed the observ	time, the ^{US FOIA (b)(6)}					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG 01	(X3) DATE SURVEY COMPLETED			
315124		315124	B. WING			06/26/2024		
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA	D 4.T.C.	N	
K 281	Continued From page	e 2	K 2	281				
	The U.S. FOIA (b) (6) was informed of the findings at the Life safety Code exit conference on 6/19/24. N.J.A.C. 8:39-31.2 (e) Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9							
K 321 SS=E			К 3	321		8/25/24		
	e. Trash Collection R (exceeding 64 gallons f. Combustible Storag (over 50 square feet) g. Laboratories (if cla Hazard - see K322)	ed Heater Rooms han 100 square feet) ce, and Paint Shops ns (exceeding 64 gallons) coms s) ge Rooms/Spaces						

K 321 Continued From page 3 by: Based on observations and interviews on 6/18/24 and 06/19/2024, in the presence of the USFOIA (b)(6) If was determined that the facility failed to ensure that 2 of 5 hazardous area doors located in the basement were self closing or automatic closing in accordance with NFPA 101 2012 Edition, Sections 19.3.2, 19.3.2.1.3 and 19.3.2.1.5. This deficient practice had the potential to affect all 94 residents and was evidenced by: An observation 06/18/2024 at 2:55 PM, revealed the basement fire panel room door did not have a self closer or automatic closer. The room is used for storage of combustible material and is greater than 50 sqft. In an interview at the time, the USFOIA (b)(6) Confirmed the observation. An observation on 06/18/2024 at 3:05 PM, revealed the maintenance shop door did not have a self closer or automatic closer. In an interview at the time, the USFOIA (b)(6) confirmed the observation. The USFOIA (b)(6) It was determined that 2 of 5 hazardous area doors located in the basement. (see attached document labeled K321) 2. All residents have the potential to be affected this practice. 3. The Director of Maintenance will conduct an audit of all doors in the facility that need a self-close mechanism to determine compliance. 4. The Director of Maintenance will conduct weekly audits for 5 weeks and then monthly thereafter for 3 months of all doors in the facility in the potential to be affected this practice. 3. The Director of Maintenance will conduct weekly audits for 5 weeks and then monthly thereafter for 3 months of all doors which need a self-close mechanism to determine compliance. 4. The Director of Maintenance will conduct weekly audits for 5 weeks and then monthly thereafter for 3 months of all doors which need a self-close mechanism to determine compliance. 5. The Director of Maintenance will conduct weekly audits for 5 weeks and then monthly thereafter for 3 months of all doors which need a self-close Acommittee will meet quarterly, and all findings will be	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G 01	(X3) DATE SURVEY COMPLETED
DELLE CARE NURSING AND REHABILITATION CENTER (A4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SEP PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (A321 Continued From page 3 by: Based on observations and interviews on 6/18/24 and 06/19/2024, in the presence of the STATEMENT of Description (A18/204) and 06/19/2024, in the presence of the STATEMENT of DESCRIPTION (A18/204) and 06/19/2024, in the presence of the STATEMENT of DESCRIPTION (A18/204) and 06/19/2024, in the presence of the STATEMENT of DESCRIPTION (A18/204) and 06/19/2024, in the presence of the STATEMENT OF DEFICIENCY) It was determined that the facility failed to ensure that 2 of 5 hazardous area doors located in the basement were self closing or automatic closing in accordance with NPPA 101 2012 Edition, Sections 19.3.2, 19.3.2.1.3 and 19.3.2.1.5. This deficient practice had the potential to affect all 94 residents and was evidenced by: An observation 06/18/2024 at 2:55 PM, revealed the basement fire panel room door did not have a self closer or automatic closer. The room is used for storage of combustible material and is greater than 50 sqft. In an interview at the time, the STOTATORS confirmed the observation. An observation on 06/18/2024 at 3:05 PM, revealed the maintenance shop door did not have a self closer or automatic closer. The room is used for storage of combustible material and is greater than 50 sqft. In an interview at the time, the STOTATORS confirmed the observation. The STOTATORS CALL THE ARROW THE TAKE			315124	B. WING		06/26/2024
FREEDY TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K 321 Continued From page 3 by; Based on observations and interviews on 6/18/24 and 0/6/19/2024, in the presence of the USFO/A (b) (6) It was determined that the facility failed to ensure that 2 of 5 hazardous area doors located in the basement were self closing or automatic closing in accordance with NFPA 101 2012 Edition, Sections 19.3.2, 19.3.2.1.3 and 19.3.2.1.5. This deficient practice had the potential to affect all 94 residents and was evidenced by: An observation 06/18/2024 at 2:55 PM, revealed the basement tire panel room door did not have a self closer or automatic closer. The room is used for storage of combustible material and is greater than 50 sqft. In an interview at the time, the USFO/A (b) (6) Confirmed the observation. The SECIAL DECENCY (1) K 345 E/R A345 E/R A346 E/R A347 Fire Alarm System - Testing and Maintenance A 221 K 321 K 321 K 322 K 325 K 326 K 3345 E/R A346 Fire Alarm System - Testing and Maintenance A 232 K 325 K 3346 E/R A347 Fire Alarm System - Testing and Maintenance			ABILITATION CENTER		439 BELLEVUE AVENUE	
by: Based on observations and interviews on 6/18/24 and 06/19/2024, in the presence of the US FOIA (b)(6) It was determined that the facility failed to ensure that 2 of 5 hazardous area doors located in the basement were self closing or automatic closing in accordance with NFPA 101 2012 Edition, Sections 19.3.2, 19.3.2.1.3 and 19.3.2.1.5. This deficient practice had the potential to affect all 94 residents and was evidenced by: An observation 06/18/2024 at 2:55 PM, revealed the basement fire panel room door did not have a self closer or automatic closer. The room is used for storage of combustible material and is greater than 50 sqft. In an interview at the time, the US FOIA (b)(6) It was determined that the facility failed to ensure that 2 of 5 hazardous area doors located in the basement. (see attached document labeled K321) 2. All residents have the potential to be affected this practice. 3. The Director of Maintenance will conduct an audit of all doors in the facility that need a self-close mechanism to determine compliance. 4. The Director of Maintenance will conduct weekly audits for 5 weeks and then monthly thereafter for 3 months of all doors in the facility to ensure that all doors which need a self-close mechanism do indeed have one. The QA committee will meet quarterly, and all findings will be brought up to the QA committee for 2 quarters. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The US FOIA (b)(6) Fire Alarm System - Testing and Maintenance K 345 Fire Alarm System - Testing and Maintenance	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETION
SS=F CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 321	by: Based on observation and 06/19/2024, in the US FOIA (b)(6) that the facility failed hazardous area doors were self closing or a accordance with NFP Sections 19.3.2, 19.3 deficient practice had residents and was ev An observation 06/18 the basement fire parself closer or automate for storage of combust than 50 sqft. In an interview at the confirmed the observation on 06 revealed the maintent a self closer or automates a self closer or automates. The U.S. FOIA (b) (6) was the Life Safety Code of the confirmed the observation on 06 revealed the maintent of the observation on 06 revealed the maintent of the observation of the obs	it was determined to ensure that 2 of 5 solocated in the basement automatic closing in A 101 2012 Edition, 12.1.3 and 19.3.2.1.5. This the potential to affect all 94 idenced by: 1/2024 at 2:55 PM, revealed the room door did not have a fic closer. The room is used stible material and is greater time, the US FOIA (b)(6) ation. 1/18/2024 at 3:05 PM, ance shop door did not have atic closer. 1/18/2024 at 3:05 PM, ance shop door did not have atic closer. 1/18/2024 at 3:05 PM, ance shop door did not have atic closer. 1/18/2024 at 3:05 PM, ance shop door did not have atic closer.	K 32	 The facility immediately installed self-door closers on 2 hazardous are doors located in the basement. (see attached document labeled K322. All residents have the potential traffected this practice. The Director of Maintenance will conduct an audit of all doors in the fathat need a self-close mechanism to determine compliance. The Director of Maintenance will conduct weekly audits for 5 weeks are then monthly thereafter for 3 months doors in the facility to ensure that all which need a self-close mechanism of indeed have one. The QA committee meet quarterly, and all findings will be brought up to the QA committee for 2 	a 21) to be cility and of all doors do will e
A fire alarm system is tested and maintained in		CFR(s): NFPA 101 Fire Alarm System - 7	esting and Maintenance	K 34	1 5	8/25/24

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG 01		DATE SURVEY COMPLETED
		315124	B. WING _			06/26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND REI	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 439 BELLEVUE AVENUE TRENTON, NJ 08618	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
K 345	with the requirement Electric Code, and N and Signaling Code. acceptance, mainter available. 9.6.1.3, 9.6.1.5, NFF This REQUIREMEN by: Based on observation the presence of the it was determinensure the inspection single station battery the residents rooms 2010 Edition. The depotential to affect all by: An observation tour residents rooms between the presence of the potential to affect all by: An observation tour residents rooms between the single samoke alarms moun residents rooms. In an interview at 10 the US FOIA (b)(6) if the manufacturers requirecord of the tests. To smoke alarms were that the smoke alarm were no documents. The US FOIA (b)(6) was a signal of the tests. The US FOIA (b) (c) was a signal of the tests. The US FOIA (b) (c) was a signal of the tests. The US FOIA (b) (c) (c) (c) (c) (c) (c) (d) (d) (d) (d) (d) (d) (d) (approved program complying is of NFPA 70, National IFPA 72, National Fire Alarm Records of system nance and testing are readily PA 70, NFPA 72 T is not met as evidenced on and interview on 6/19/24, in a system of the first and second floor of the first and the stated that the first and the stated and there or records kept.	К3	1. The Maintenance Directinspection of all 46 single soperated smoke alarms in rooms. (see attached document la 2. All residents have the affected by this practice. 3. The maintenance depeducated on the regulation single station battery opera alarms are inspected in active NFPA 72. 4. Audit will be done by the director/designee weekly for then monthly for 3 months facility is up to date with the smoke alarm inspections. Will be shared quarterly with committee for 2 quarters.	station battery the resident's abeled K345_ potential to be partment will be n of ensuring all ated smoke becordance with the maintenance or 4 weeks and to ensure the le required Audit findings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
		315124	B. WING		06/26/2024		
	ROVIDER OR SUPPLIER ARE NURSING AND REF	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE FRENTON, NJ 08618	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
K 531 K 531 SS=F	Continued From pag Elevators CFR(s): NFPA 101 Elevators	e 5	K 531 K 531		8/25/24		
	2012 EXISTING Elevators comply wit Elevators are inspect ASME A17.1, Safety Escalators. Firefighte monthly with a writte Existing elevators co Safety Code for Exis Escalators. All existin distance of 25 feet o level that best serves personnel for firefigh Firefighter's Service A17.3. (Includes firefighter's service Foperation, machine relevator lobby smoked 19.5.3, 9.4.2, 9.4.3 This REQUIREMEN' by: Based on observation in the presence of the it was determinensure operational econnections were premergency operation of 2 elevators in acceledition, Sections 19. 9.4.6. These deficier to affect all 94 reside	onform to ASME/ANSI A17.3, sting Elevators and ang elevators, having a travel or more above or below the set the needs of emergency sting purposes, conform with Requirements of ASME/ANSI fighter's service Phase I key stector automatic recall, Phase II emergency in-car key room smoke detectors, and a detectors.) T is not met as evidenced ons and interview on 6/19/24,		1. The facility immediately contacted televator vendor to ensure operational elevator emergency phone connection are provided and firefighters emergency operation tests are performed on 2 of 2 elevators. (see attached document labeled K5312. All residents have the potential to be affected by this practice. 3. All elevators were audited and were proper working condition at the time. Maintenance dept. was in-serviced on ensuring all inspections are conducted a timely fashion.	s cy 2 () e		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG 01	(X3) DATE SURVEY COMPLETED
		315124	B. WING _		06/26/2024
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 439 BELLEVUE AVENUE TRENTON, NJ 08618	•
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLÉTION OF THE APPROPRIATE DATE
K 531	key recall tests willost the key. The performed and the time of interview. #1 serves 5 levels An observation at revealed the emergand not operations emergency phone monitor to render performed again will be a surveyor that to phone connection the front desk recalled not go through the surveyor that to phone. In an interview, at confirmed the observation at revealed when the pressed a busy signot connect to a nation of the same results. In an interview at confirmed the observation the same results. In an interview at confirmed the observation the same results. The US FOIA (b)(6) the Life Safety Control of the safety Control of	and firefighters Phase 1 and 2 th written record because they confirmed the tests were not be every at the elevator #2 serves 4 levels and a both greater than 25 feet. 10:18 AM of elevator #2 revealed it did not connect to a consistance. The test was with the same results. 10:18 the time the stated the is supposed to go through to reptionist, but he checked and it in. The receptionist confirmed to the call did not show on her 10:28 AM of elevator #1 results. 10:28 AM of elevator #1 results with elevator to render assistance. The energency phone button was gnal followed and the phone did nonitor to render assistance. The energency phone button was gnal followed and the phone did nonitor to render assistance. The energency elevator #1 results was informed of the findings at defect the previous of the	K	4. Weekly audits of eleva will be completed by Mair or Designee for four week thereafter for 3 months to elevators are up to date of and are complying. Findir brought to the QAPI common for 3 months.	ntenance Director ks, and monthly ensure that all on inspections ngs will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
		315124	B. WING		06/26/2024		
	ROVIDER OR SUPPLIER ARE NURSING AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 439 BELLEVUE AVENUE TRENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D 4.7	ETION	
K 531	Continued From page emergency communic N.J.A.C. 8:39-31.2 (e	cation failure.	K 53 ²		8/25/2-	:4	
SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 6/19/24, in the presence of the US FOIA (b)(6) , it was determined that the facility failed to ensure the guarding of live parts of electrical equipment and controls within an unlocked electrical panel in a resident accessible area for 1 of 3 electrical panels observed, in accordance with NFPA 101, 2012 Edition, Section 19.5.1.1, 9.1.2, NFPA 99 2012 Edition, Section 6.3.2.1, 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26, 110.27 and 110.16. This deficient practice had the potential to affect 94 residents and was evidenced by the following: At 10:53 AM, the surveyor US FOIA (b)(6), observed an unlocked electrical wall panels on the resident occupied 2nd floor in the exit/egress corridor by room #26.			1. The electrical wall panel on the resident occupied 2nd floor was immediately secured and locked. (see attached document labeled K912. All residents have the potential to affected by this practice. 3. The maintenance director will doweekly environmental rounds by 4 we and monthly for 3 months to ensure al electrical panels are locked and secur 4 Audit findings will be reported to the Quality Assurance committee monthly the next 4 months. Based on the result hese audit a decision will be made regarding the need for continued submission and reporting.	eks ed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315124	B. WING _			06/26/202		
	ROVIDER OR SUPPLIER ARE NURSING AND REH	IABILITATION CENTER		439	REET ADDRESS, CITY, STATE, ZIP CODE B BELLEVUE AVENUE BENTON, NJ 08618			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
K 911	Continued From page		K	911				
		as informed of the findings at exit conference on 6/19/24.						
K 918 SS=F			K	918			8/25/24	
	Maintenance and Tes The generator or oth and associated equip service within 10 sec criterion is not met du process shall be prov capability for the life is Maintenance and tes transfer switches are with NFPA 110. Generator sets are in under load 30 minute day intervals, and ex months for 4 continue under load conditions simulated cold start a transfer of all EES loa competent personnel stored energy power accordance with NFF circuit breakers are in program for periodica components is estab manufacturer require maintenance and tes readily available. EES circuits are marked, re	ner alternate power source oment is capable of supplying onds. If the 10-second uring the monthly test, a vided to annually confirm this safety and critical branches. Iting of the generator and performed in accordance aspected weekly, exercised as 12 times a year in 20-40 ercised once every 36 ous hours. Scheduled test is include a complete and automatic or manual ads, and are conducted by I. Maintenance and testing of sources (Type 3 EES) are in PA 111. Main and feeder aspected annually, and a ally exercising the						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G 01		ATE SURVEY OMPLETED
		315124	B. WING _			06/26/2024
	ROVIDER OR SUPPLIER ARE NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 439 BELLEVUE AVENUE TRENTON, NJ 08618		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 918	the possibility of dar source is a design of installations. 6.4.4, 6.5.4, 6.6.4 (I 111, 700.10 (NFPA This REQUIREMEN by: Based on interview 6/18/24, in the pressort facility failed to dem fuel supply from the Company in accord Edition Chapter 6 a Section 5.1. This depotential affect all results and a natural gas possible of the potential affect all results and a natural gas po	mage of the emergency power consideration for new NFPA 99), NFPA 110, NFPA 70) IT is not met as evidenced and record review on ence of the US FOIA (b)(6) it was determined that the constrate reliability regarding Natural Gas Supply ance with NFPA 99, 2012 and NFPA 110, 2010 Edition efficient practice had the esidents and is evidenced by: 2:00 AM revealed the facility owered generator. Deproximately 2:00 PM, the did not have a documented the natural gas provider. as informed of the findings at exit conference on 6/19/24.	К9	1. The facilities Natural gas immediately contacted to pro documented reliability letter. (see attached document labe 2. All residents have the posificated by this practice. 3. The maintenance departmeducated on the regulation of reliability letter is on file from natural gas supplier. 4. Audit will be done by the modirector/designee annually to facility is up to date with the reliability letter. Audit findings shared with the QAPI commits.	eled K918) eled K918) etential to be ent will be f ensuring a the facility's naintenance ensure the required s will be	

POST-CERTIFICATION REVISIT REPORT

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PROVIDE IDENTIFIC				MULTIPLE CONS A. Building 01		IURSING CENT	ED				DATE O	F REVISIT
315124	AHONN	OWIDER		B. Wing	- CAPITAL N	IURSING CENT	EK			Y2	8/30/20	24 _{Y3}
NAME OF	FACILITY	<u> </u>					STREE	T ADDRESS, CIT	Y, STATE, ZIF	CODE	•	
BELLE C	ARE NU	RSING	AND REH	ABILITATION C	ENTER		439 BE	LLEVUE AVENUE	Ē			
							TRENT	ON, NJ 08618				
program,	to show and the number	those of date so and the	deficiencies uch correct	s previously repositive action was a	orted on the accomplished	CMS-2567, Stat d. Each deficien	ement of I cy should	Deficiencies and be fully identifie	Plan of Cor d using eithe	ent Amendments rection, that have er the regulation of of each requiren	e been or LSC	
ITE	М			DATE	ITEM			DATE	ITEM			DATE
Y4				Y5	Y4			Y5	Y4			Y5
ID Prefix				Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#	NFPA 10	1		Completed	Reg. #	NFPA 101		Completed	Reg.#	NFPA 101		Completed
LSC	K0281			08/25/2024	LSC	K0321		08/25/2024	LSC	K0345		08/25/2024
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ID Prefix				Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#	NFPA 10	1		Completed	Reg. #	NFPA 101		Completed	Reg.#	NFPA 101		Completed
LSC	K0531			08/25/2024	LSC	K0911		08/25/2024	LSC	K0918		08/25/2024
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