STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315124	A. BUILDING _____ B. WING _____	C 06/29/2023

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 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 000	INITIAL COMMENTS C#: NJ165092 CENSUS: 86 SAMPLE SIZE: 4 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/19/2023

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) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061101	A. BUILDING: _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLE CARE NURSING AND REHABILITATION CENTI	439 BELLEVUE AVENUE TRENTON, NJ 08618

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H3470	8:43E-10.11(c)(2) Other Rprtng Rqrmnts Unrltd to Pt Sfty Act Examples of reportable events in the nature of physical plant and operational interruptions, include, but are not limited to, the following: Loss or significant reduction of water, electrical power, or any other essential utilities necessary to the operation of the facility. This REQUIREMENT is not met as evidenced by: NJ#165398 Based on documentation review on 6/28/23 in the presence of facility management, it was determined that the facility failed to report the loss of the freight elevator, which resulted in both elevators not being in operation for more than 3 hours, to the Department of Health (DOH). This deficient practice was evidenced by the following: An interview with the Maintenance Director revealed that the facility lost the freight elevator power on 6/20/23 at 8:04 PM and wasn't fixed until 6/21/23 in the morning. An interview with the DON revealed the freight elevator was fixed at 9:00 AM the next morning. A review of the facility's elevator repair invoice had a repair date of 6/21/23. This interruption of the freight elevator service was not reported to the DOH.	H3470	1. On 6-20-23 upon identifying that the freight elevator was in a state of disrepair, the elevator repair company was immediately contacted to repair the elevator. The elevator was repaired on the morning of 6/21/2023 and immediately put back in service. The facility emergency preparedness plan was activated. 2. All residents have the potential to be affected by this alleged deficient practice. 3. Facility management team reviewed the state reporting requirements. All managers and supervisors have received in service education on reportable events and are aware to immediately report all outages to the Administrator and Director of Nursing. All future elevator outages will be reported to the Department of Health. 4. The maintenance director will monitor all elevator outages to ensure that the elevator outages were properly reported and addressed. The maintenance director	7/16/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061101	A. BUILDING: _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLE CARE NURSING AND REHABILITATION CENTI	439 BELLEVUE AVENUE TRENTON, NJ 08618

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H3470	Continued From page 1	H3470	/designee will and report to the Quality Assurance & Performance Improvement Committee on a monthly basis for 3 months then quarterly for QAPI committee review and recommendations.	
S 000	Initial Comments C#: NJ165092 CENSUS: 86 SAMPLE SIZE: 4 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
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. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct	S 560	1. Efforts to hire facility staff will continue and use of agency staff (Nurses and CNAs) will also continue to be utilized to	7/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 care staff to resident ratios as mandated by the State of New Jersey. This was evident for 7 out of 14 day shifts and 1 out of 14 overnight shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 6/11/23 to 6/24/23 for the 6/29/23 complaint survey at Belle Care, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts and deficient in total staff on 1 of 14 overnight shifts as follows:	S 560	fill vacancies in the schedule. 2. All residents have the potential to be affected by this deficient practice. 3. -Staffing Coordinator and Nursing supervisors were in-serviced on 7/12/23 and 7/13/23 by the Director of Nursing on minimum staffing requirements. -Recruitment efforts (on line job listings, job fairs, referral bonuses) will be on-going. In- house bonuses and overtime will be utilized where applicable. -Upon completion of the monthly schedule, staffing coordinator will continue to submit same to Administrator, Director of Nursing and Assistant Director of Nursing for review. Daily Staffing Sheets will also continue to be reviewed to ensure compliance with minimum staffing requirements . 4. -Weekly, Staffing Coordinator will audit Daily Staffing Sheets to ensure that staffing complies with staffing ratios. Audits will be completed weekly x 4 weeks, monthly x 3 months and quarterly x 1 quarter. Audits will be reviewed during Quarterly QAPI meetings x 1quarter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 3 6/11/23 had 9 CNAs for 86 residents on the day shift, required 11 CNAs. 6/12/23 had 10 CNAs for 85 residents on the day shift, required 11 CNAs. 6/15/23 had 9 CNAs for 85 residents on the day shift, required 11 CNAs. 6/16/23 had 6 CNAs for 86 residents on the day shift, required 11 CNAs. 6/17/23 had 6 CNAs for 86 residents on the day shift, required 11 CNAs. 6/18/23 had 6 CNAs for 86 residents on the day shift, required 11 CNAs. 6/18/23 had 5 total staff for 86 residents on the overnight shift, required 6 total staff. 6/23/23 had 7 CNAs for 84 residents on the day shift, required 10 CNAs. NJAC 8:39-5.1(a)	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061101		7/25/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLE CARE NURSING AND REHABILITATION CENTER	439 BELLEVUE AVENUE TRENTON, NJ 08618

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix H3470 Reg. # 8:43E-10.11(c)(2) LSC	Correction Completed 07/16/2023	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
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 6/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		☐ YES ☐ NO	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061101 Y1	A. Building B. Wing Y2	7/25/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLE CARE NURSING AND REHABILITATION CENTER	439 BELLEVUE AVENUE TRENTON, NJ 08618

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ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	H3470	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	8:43E-10.11(c)(2)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		07/16/2023	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
6/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061101	A. Building B. Wing	7/25/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLE CARE NURSING AND REHABILITATION CENTER	439 BELLEVUE AVENUE TRENTON, NJ 08618

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 07/16/2023	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
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
6/29/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO