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	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belle Care Nursing and Rehabilitation Center	439 Bellevue Avenue Trenton, NJ 08618

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45209 Complaint NJ #: 159451; 159783 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain an environment that promoted maintenance or enhancement of the resident's quality of life. This deficient practice was identified for 1 of 1 residents reviewed for Resident Rights (Resident #60). This deficient practice was evidenced by the following: On 6/17/24 at 10:27 AM, the surveyor observed Resident #60 in their room watching television. Resident #60 stated that they did not like to spend time in their room because their roommate (Resident #71) urinated on the floor, causing the room to become smelly and unpleasant. When asked if the facility was aware of this behavior, Resident #60 confirmed. On 6/20/24 at 10:52 AM, the surveyor was on the Second Floor nursing unit and smelled a strong odor of urine while approaching Resident #60's room. The surveyor entered the room to discover the floor by Resident #60's bed was wet and sticky in addition to puddles of wetness observed on the bed. Upon exiting the room, the surveyor observed two facility staff sitting in the alcove across from the resident's room engaged in conversation. On 6/20/24 at 11:41 AM, the surveyor requested that Registered Nurse (RN #1) walk with them to Resident #60's room. While approaching the room, RN #1 acknowledged the strong odor of urine and confirmed that they were aware of the room's condition approximately 30 minutes prior to the surveyor being on the floor. RN #1 stated that they notified housekeeping and instructed the certified nursing aides to clean the room. RN #1 stated that they were under the impression that it was rectified. On 6/20/24 at 11:55 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) stated that the rooms were to be considered as the resident's home. The UM/LPN stated that Resident #60 should not have to sit in a room that smells of urine, confirmed that the entire hallway by Resident #60's room smelled of urine and that the two facility staff members sitting in the alcove should have attempted to identify the location of the smell to clean it up. The surveyor reviewed the medical record for Resident #60. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024

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Belle Care Nursing and Rehabilitation Center	439 Bellevue Avenue Trenton, NJ 08618

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Admission Record face sheet (an admission summary) reflected that resident was admitted to the facility with diagnosis that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one entire side of the body) following cerebral infarction (stroke) affecting left dominant side, candidiasis (fungal infection) of skin and nail, and bipolar disorder. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 4/16/24, reflected a brief interview for mental status (BIMS) score of 12 out of 15, which indicated a moderately impaired cognition. On 6/25/24 at 9:43 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the resident room should have been cleaned in a timely fashion and that residents should have the expectation to receive quality care and quality living environments. On 6/26/24 at 10:35 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the Regional Nurse and Assistant Director of Nursing (ADON), and DON, acknowledged that the facility was aware of ongoing issue with Resident #60's room, but have never approached the resident to discuss whether or not this living condition impacted them. A review of the facility's Resident Rights policy, created 2/2024, included .The resident has a right to a safe, clean, comfortable and Homelike Environment, including but not limited to receiving treatment and supports for daily living safely . A review of the facility's undated Quality of Life- Homelike Environment policy included .2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order .e. Pleasant, neutral scents . A review of the facility's undated Certified Nurse Aide Position document included .22. Ensures that residents and families receive the highest quality of service in a caring and compassionate atmosphere which recognizes the individuals' needs and right . A review of the facility's undated Licensed Practical Nurse Position document included .9. Supervises and coordinates nursing personnel in providing direct resident care in adherence with state and federal regulations. 10. Ensures that residents and families receive the highest quality of service in a caring and compassionate atmosphere which recognizes the individuals' needs and right . A review of the facility's undated Registered Nurse Position document included .2. 9. Supervises and coordinates nursing personnel in providing direct resident care in adherence with state and federal regulations. NJAC 8:39-4.1 (a), 11

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that Justice Involved Residents (JIRs) were treated in a dignified and respectful manner by physically restraining, secluding the resident from participating in group activities, community dining, communicating with visitors, leaving the room at will, and retaining and using of personal possessions. This deficient practice was identified for 1 of 1 JIR (Resident #1). Resident #1 was admitted to the facility on [DATE], and was secluded by Corrections Officers (CO) from the Correctional Facility (CF). Resident #1 was observed being secluded to their room, guarded by two COs, and they were not permitted to participate in group activities and community dining. Resident #1 stated they were not allowed to leave their room; have visitors unless scheduled and approved by the CF; could not choose their own clothes having to wear an orange jumpsuit that made them feel embarrassed; participate in activities; eat all meals in their room on disposable ware; not allowed use the telephone; and had no privacy which the resident reported feeling lonely and depressed being in a room twenty-four hours a day seven days a week with two CFs and a television. Resident #1 stated they wanted to return to the CF because of it. The facility's failure to ensure all residents, including JIRs, had the right to a dignified existence posed a likelihood to cause serious injury and psychological harm. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 8/29/24, and the facility Administration was notified of the IJ on 8/29/24 at 4:29 PM. The facility submitted an acceptable Removal Plan (RR) on 8/30/24 at 1:44 PM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 8/30/24. The findings were as follows: Reference: The Centers for Medicare and Medicaid Services (CMS) updated Guideline to Surveyors on Federal Requirements for Providing services to Justice Involved individuals, revised 12/23/2016 S & C 16-21-ALL documented Skilled Nursing Facilities must permit residents to have autonomy and choice to the maximum extent practicable regarding how they wish to live their everyday lives and receive care with the same rights as nursing home residents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's Resident Rights dated revised 1/3/24, included 1. prior to or upon admission, the social service designee [.] will inform the resident and/or the resident's representative of the resident's rights and responsibilities .10. all residents will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression .Resident Rights: 1. the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility .5. the resident has the right to be treated with respect and dignity including: the right to be free from physical or chemical restraints imposed for the purpose of discipline or convenience [.] the right to retain and use personal possessions [.] the right to receive services in the facility with reasonable accommodation of resident needs and preferences [.]the right to share a room with a roommate of his/her choice [.] 6. Self-determination: the resident has the right to and the facility must 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 with members of the community; receive visitors of their choosing at the time of their choosing .participate in other activities including social, religious, and community activities .8. Privacy and confidentiality: the resident has the right to personal privacy and confidentiality of their personal and medical records .9. Safe environment: the resident has the right to a safe, clean, comfortable and homelike environment . On 8/29/24 at 9:45 AM, the surveyor observed a personal protective equipment (PPE) bin outside of Resident #1's room. At that time, the surveyor interviewed the Licensed Practical Nurse Supervisor (LPN Supervisor #1), who stated [Resident #1] had a stage 4 pressure wound (full-thickness skin loss extends through the fascia with considerable tissue loss) to their right buttock, and when staff provided care, they needed to don (wear) additional PPE. The surveyor asked if staff had to wear PPE when the resident was out of the room, and LPN Supervisor #1 stated that Resident #1 was a JIR who remained in their room unless to go to the rehabilitation (rehab) gym. The LPN Supervisor #1 stated that Resident #1 did not participate in activities; ate all their meals in their room on disposable ware; wore an orange jumpsuit in therapy; visitors needed to be scheduled through the CF by appointment; and Resident #1 always remained in the room alone with two armed COs. The LPN Supervisor #1 stated that the nurses and Certified Nursing Aides (CNAs) were permitted in the room to provide resident care. (continued on next page)

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F 0557 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/29/24 at 9:55 AM, the surveyor observed Resident #1 lying in bed with two-armed COs (CO #1 and CO #2) who were stationed at the resident's door (CO #1) and the resident's window (CO #2). At that time, the surveyor interviewed Resident #1, who stated they had been at the facility for over a year now, and they were receiving rehab and wound care at the facility. Resident #1 stated that they wanted to return to the CF; they were lonely and depressed at the facility because they remained in their room twenty-four hours a day, seven days a week with two COs and a television. Resident #1 stated they ate in their room on disposable ware and there were no activities. Resident #1 further stated that they were prohibited visitors unless the CF approved the visits, and the CF was not responding to their visitors for appointments. Resident #1 stated they were waiting for grievance paperwork from the CF to complain about it, which they had not received, and the CF's Social Worker (SW) was supposed to come to the facility weekly so they could have their weekly phone call. Resident #1 stated the CF's SW maybe came to the facility twice a month, so they missed their allowed phone calls, and the resident wanted to call their attorney to request to be transferred back to the CF. Resident #1 stated they had no privacy, anytime they received care the COs were in the room, and if they had visitors or made a call, the COs were present. Resident #1 stated that when they went to rehab, they wore an orange jumpsuit which embarrassed them because it let everyone know they were a JIR. The surveyor asked if the resident had to wear any cuffs (wrist or ankle) in the room or in rehab, and the resident stated, no, they could not walk. The surveyor asked if the resident saw the facility's SW, and the resident stated, no, but they thought they were supposed to. At the time of the interview, the surveyor asked CO #1 if everything the resident reported was accurate, and the CO stated yes, the resident was incarcerated. On 8/29/24 at 10:41 AM, the surveyor reviewed the medical record for Resident #1. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; paraplegia (leg paralysis); chronic pain; depressive disorder; anxiety disorder; insomnia; and stage 4 pressure ulcer of right buttock. A review of the Progress Notes included a Nursing Note dated 4/27/23 at 7:37 AM, which included the resident was admitted to the facility on [DATE] at 6:55 PM, accompanied by two COs. The resident was admitted with a right ischial (lower buttock) pressure sore; was receiving intravenous (IV) antibiotics; and had a wound vacuum (negative pressure wound therapy treatment that uses suction to assist in wound healing). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 7/31/24, reflected the resident had a brief interview for mental status score of 15 out of 15, indicating that the resident had an intact cognition. A review of the individual comprehensive care plan (ICCP) included the following focus areas: A focus area dated 7/3/24, revealed that the resident was not permitted access to telephones, not landlines or cell phones. In the rare circumstances when phone use was permitted, the CF, not the staff take care of it. The resident was not permitted to go out on pass or out of the facility unless escorted by COs and authorized by the CF. The intervention was that the resident would be closely monitored by the CF. (continued on next page)

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Belle Care Nursing and Rehabilitation Center	439 Bellevue Avenue Trenton, NJ 08618

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F 0557 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A focus area dated 7/3/24, indicated inmate 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 would maintain stable weight and be free from dehydration. A focus area dated 8/11/24, revealed that the resident had depression with regards to lifestyle changes. Interventions included to administer medications as ordered; monitor, document, and report as needed any signs and symptoms of depression; and monitor, record, and report to physician as needed the risk for harming others. On 8/29/24 at 11:01 AM, the surveyor interviewed the Director of Rehab (DOR), who stated Resident #1 participated in physical therapy (PT) three to five times a week in the rehab gym. The DOR stated that [Resident #1] was transferred to the rehab gym by two COs who always remained with them, and there were no other residents present. The DOR stated [Resident #1] did not require any ankle or wrist cuffs because they were paraplegic. The DOR stated that Resident #1 was working on ambulating (walk) and transferring; and that their goal was to walk in their room and use the bathroom independently. The DOR stated that [Resident #1] was currently transferring out of bed (oob) with supervision. The surveyor questioned the diagnosis of paraplegic if the resident was walking, and the DOR stated the resident was a paraplegic and rehab was working with them to walk. On 8/29/24 at 11:24 AM, the surveyor interviewed the facility's SW, who stated she had just started at the facility last week and had not gotten to speak to all the residents yet. The surveyor asked if the SW spoke with Resident #1, and she stated no, but the resident was on her list. On 8/29/24 at 11:55 AM, the surveyor interviewed the Director of Activities (DA) who stated activities were conducted in groups on both nursing units, and staff did one-to-one (1:1) activities as needed. The DA stated that 1:1 activities included providing puzzles and crossword puzzles. The surveyor asked if she provided 1:1 activities for Resident #1, and the DA stated that activity staff did not see [Resident #1] that often. The DA stated that there were two COs in there and staff were not really supposed to be in there; that she could not provide any activities, crossword puzzles, or games. The DA stated [Resident #1] requested a pack of playing cards about a month ago, and the facility was not allowed to provide, that the CF's SW had to provide. On 8/29/24 at 12:15 PM, the surveyor interviewed Resident #1's assigned CNA (CNA #1), who stated [Resident #1] provided their own care; that they were able to get out of bed and go to the bathroom by themselves, and the resident was permitted out of their room to the shower room with the two COs, and the CNA provided the washcloth and towel. CNA #1 stated when [Resident #1] showered, it was just the resident in the room with the two COs. CNA #1 stated that [Resident #1] always ate all their meals in their room on disposable ware with the two COs in the room. On 8/29/24 at 12:20 PM, the surveyor interviewed LPN #1 in the presence of LPN #2, who stated that [Resident #1] received wound care for a small wound on their buttock that was more of a tunneling hole than a wound. LPN #1 stated the wound was the width of a cotton swab, and [Resident #1] saw a wound doctor outside the facility because they refused to see the facility's wound doctor. LPN #1 stated that there were always two-armed COs with [Resident #1], and the only time [Resident #1] left their room was for rehab and doctor's appointments. The surveyor asked how often the resident had wound doctor appointments, and LPN #2 stated she was unsure if there was a set schedule, but [Resident #1] had an appointment today. LPN #2 stated that the CF setup the transportation, and the COs accompanied [Resident #1] to and from the appointment. (continued on next page)

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F 0557 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/29/24 at 12:30 PM, the surveyor observed Resident #1 sitting in a wheelchair being transported down the hallway in wrist and ankle cuffs in an orange jumpsuit with three-armed COs. The surveyor asked Resident #1 where they were going, and Resident #1 stated to see the wound doctor, that they did not want to see the doctor here. Resident #1 stated their appointment was at the hospital, and that their wound was improving. The surveyor asked Resident #1 if they ever received the playing card they requested, and Resident #1 stated no. The surveyor then observed Resident #1 with two COs (CO #2 and CO #3) and no residents or staff, use the elevator to go downstairs. At that time, the surveyor asked CO #1 why [Resident #1] needed to wear hand and ankle cuffs, since it was reported earlier that the resident did not need because they could not walk. CO #1 stated it was protocol when the JIR left the building. The surveyor asked how [Resident #1] was transferred to the hospital, and the CO stated on a medical bus from the CF. On that same date, the surveyor observed Resident #1 being escorted out of the building by four COs. On 8/29/24 at 12:56 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the DON, who stated that she had started at the facility on 4/11/24, and the previous owners of the facility had a contract with the CF since 2022. The LNHA stated that the JIRs were only at the facility for medical services, and when their medical treatment was completed, the JIRs returned to the CF. The LNHA stated that [Resident #1] stayed in their room with the two COs and went to rehab accompanied by them. The LNHA stated that everything was controlled by the CF; that the facility could not provide playing cards; phone usage; visitors. The LNHA stated the CF's SW came to the facility she thought once a month for [Resident #1] to make a phone call, but she did not believe there was a set schedule. At that time, the DON stated that [Resident #1] informed the facility that the CF had to approve all visits, and the resident could not have a visitor unless the CF approved it. The DON stated there were no private visits, that there were always COs; and that [Resident #1] could not be without them. The DON stated it was the CF's policies; that [Resident #1] could have no other clothes except their orange jumpsuit that identified them as a JIR as a safety precaution. The DON stated only [Resident #1] and the COs could be in the elevator during transportation, and [Resident #1] saw an outside wound doctor that the appointments were scheduled by the CF. The DON stated [Resident #1] saw the facility's Psychiatrist as needed and could have seen the facility's wound doctor but refused. The DON stated that [Resident #1] received the same level of care as all the other residents in the facility, they just did not have the freedoms. The DON stated that [Resident #1] had wrist and ankle cuffs as safety precaution that was a standard protocol by the CF, and the facility did not control that. The DON stated that the facility was in control of [Resident #1's] nursing care, and everything else was controlled by the CF. On 8/29/24 at 1:30 PM, the surveyor reviewed the facility's policies regarding JIRs which included the following: A review of the Inmate Resident Dining policy dated 8/21/23, included it is the policy of the [facility] to provide meals and snacks in a manner that supports establish security protocols. Procedure: 1. all inmates will receive their meals and snacks and dine in their room; 2. all inmate resident meals will be served on disposable paper goods; 3. all inmate resident meals will be served with plastic utensils; metal utensils are never permitted; 4. prior to delivery of meal tray to the inmate resident the CO in attendance will be offered the opportunity to check the tray .7. there is no food or drinks other than a water pitcher (when clinically approved) be stored at bedside . (continued on next page)

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F 0557 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Inmate Phone Use policy dated 8/21/23, included 1. inmates are not routinely permitted to access telephones, not landlines or cell phones; 2. the landline will be removed from the inmate room prior to admission; 3. the staff is not to facilitate or participate in allowing inmates to use a telephone; 4. in rare circumstances when telephone use is permitted this will be entirely taken care of by the [CF staff], specifically the assigned COs; 5. at no time is [facility] staff to participate in inmate's phone use. A review of the Concerns with Correctional Officers policy dated 9/12/23, included that COs should be treated with dignity and respect by all staff . An acceptable Removal Plan (RP) on 8/30/24 at 1:44 PM indicated the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including the resident was returned to the CF on 8/29/24; the facility ended their contract with the CF to accept JIR and has no other contracts with additional CFs to accept JIRs; the LNHA and DON were inserviced regarding CMS's S & C memo regarding JIR; and the LNHA was responsible for the implementation of all facility policies and regulations. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 8/30/24. NJAC 8:39-4.1(a)12

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F 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080 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 physical restraints, and wear clothing of choice for Justice Involved Residents (JIR). This deficient practice was identified for 1 of 1 JIRs (Resident #1). Resident #1 was admitted to the facility on [DATE], and was secluded by Corrections Officers (CO) from the Correctional Facility (CF). Resident #1 was observed being secluded to their room, guarded by two COs, and they Resident #1 was not permitted to participate in group activities and community dining. Resident #1 stated that they were not allowed to leave their room; have visitors unless scheduled and approved by the CF; could not choose their own clothes having to wear an orange jumpsuit that made them feel embarrassed; participate in activities; eat all meals in their room on disposable ware; not allowed use the telephone; and had no privacy which the resident reported feeling lonely and depressed being in a room twenty-four hours a day seven days a week with two CFs and a television. Resident #1 stated they wanted to return to the CF because of it. The facility's failure to promote and facilitate resident self-determination through support of resident choice for all residents, including JIRs, to participate in group activities and dining, leave their room at will, communicate with visitors of choice, and wear clothing of choice posed a likelihood to cause serious injury and psychological harm. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 8/29/24, and the facility Administration was notified of the IJ on 8/29/24 at 4:29 PM. The facility submitted an acceptable Removal Plan (RR) on 8/30/24 at 1:44 PM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 8/30/24. The findings were as follows: Reference: The Centers for Medicare and Medicaid Services (CMS) updated Guideline to Surveyors on Federal Requirements for Providing services to Justice Involved individuals, revised 12/23/2016 S & C 16-21-ALL documented Skilled Nursing Facilities must permit residents to have autonomy and choice to the maximum extent practicable regarding how they wish to live their everyday lives and receive care with the same rights as nursing home residents. (continued on next page)

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F 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's Resident Rights dated revised 1/3/24, included .10. all residents will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression .Resident Rights: 1. the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility .6. Self-determination: the resident has the right to and the facility must 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 with members of the community; receive visitors of their choosing at the time of their choosing .participate in other activities including social, religious, and community activities .8. Privacy and confidentiality: the resident has the right to personal privacy and confidentiality of their personal and medical records .9. Safe environment: the resident has the right to a safe, clean, comfortable and homelike environment . On 8/29/24 at 9:45 AM, the surveyor observed a personal protective equipment (PPE) bin outside of Resident #1's room. At that time, the surveyor interviewed the Licensed Practical Nurse Supervisor (LPN Supervisor #1), who stated [Resident #1] had a stage 4 pressure wound (full-thickness skin loss extends through the fascia with considerable tissue loss) to their right buttock, and when staff provided care, they needed to don (wear) additional PPE. The surveyor asked if staff had to wear PPE when [Resident #1] was out of the room, and the LPN Supervisor #1 stated that [Resident #1] was a JIR who remained in their room unless to go to the rehabilitation (rehab) gym. The LPN Supervisor #1 stated that [Resident #1] did not participate in activities; ate all their meals in their room on disposable ware; wore an orange jumpsuit in therapy; visitors needed to be scheduled through the CF by appointment; and that [Resident #1] always remained in the room alone with two armed COs. 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 two-armed COs (CO #1 and CO #2) who were stationed at the resident's door (CO #1) and the resident's window (CO #2). At that time, the surveyor interviewed Resident #1, who stated they had been at the facility for over a year now, and they were receiving rehab and wound care at the facility. Resident #1 stated that they wanted to return to the CF; they were lonely and depressed at the facility because they remained in their room twenty-four hours a day, seven days a week with two COs and a television. Resident #1 stated they ate in their room on disposable ware and there were no activities. Resident #1 stated that they were prohibited visitors unless the CF approved the visits, and the CF was not responding to their visitors for appointments. Resident #1 stated they were waiting for grievance paperwork from the CF to complain about it, which they had not received, and the CF's Social Worker (SW) was supposed to come to the facility weekly so they could have their weekly phone call. Resident #1 stated the CF's SW maybe came to the facility twice a month, so they missed their allowed phone calls, and the resident wanted to call their attorney to request to be transferred back to the CF. Resident #1 stated they had no privacy, anytime they received care the COs were in the room, and if they had visitors or made a call, the COs were present. Resident #1 stated that when they went to rehab, they wore an orange jumpsuit which embarrassed them because it let everyone know they were a JIR. The surveyor asked if the resident had to wear any cuffs (wrist or ankle) in the room or in rehab, and the resident stated, no, they could not walk. The surveyor asked if the resident saw the facility's SW, and the resident stated, no, but they thought they were supposed to. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER: Belle Care Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 439 Bellevue Avenue Trenton, NJ 08618	

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F 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At the time of the interview, the surveyor asked CO #1 if everything the resident reported was accurate, and the CO stated yes, the resident was incarcerated. On 8/29/24 at 10:41 AM, the surveyor reviewed the medical record for Resident #1. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; paraplegia (leg paralysis); chronic pain; depressive disorder; anxiety disorder; insomnia; and stage 4 pressure ulcer of right buttock. A review of the Progress Notes included a Nursing Note dated 4/27/23 at 7:37 AM, which included the resident was admitted to the facility on [DATE] at 6:55 PM, accompanied by two COs. The resident was admitted with a right ischial (lower buttock) pressure sore; was receiving intravenous (IV) antibiotics; and had a wound vacuum (negative pressure wound therapy treatment that uses suction to assist in wound healing). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 7/31/24, reflected the resident had a brief interview for mental status score of 15 out of 15, indicating that the resident had an intact cognition. A review of the individual comprehensive care plan (ICCP) included the following focus areas: A focus area dated 7/3/24, revealed that the resident was not permitted access to telephones, not landlines or cell phones. In the rare circumstances when phone use was permitted, the CF, not the staff take care of it. The resident was not permitted to go out on pass or out of the facility unless escorted by COs and authorized by the CF. The intervention was that the resident would be closely monitored by the CF. A focus area dated 7/3/24, indicated inmate 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 would maintain stable weight and be free from dehydration. A focus area dated 8/11/24, revealed that the resident had depression with regards to lifestyle changes. Interventions included to administer medications as ordered; monitor, document, and report as needed any signs and symptoms of depression; and monitor, record, and report to physician as needed the risk for harming others. On 8/29/24 at 11:01 AM, the surveyor interviewed the Director of Rehab (DOR), who stated Resident #1 participated in physical therapy (PT) three to five times a week in the rehab gym. The DOR stated that [Resident #1] was transferred to the rehab gym by two COs who always remained with them, and there were no other residents present. The DOR stated [Resident #1] did not require any ankle or wrist cuffs because they were a paraplegic. The DOR stated that Resident #1 was working on ambulating (walk) and transferring; that their goal was to walk in their room and use the bathroom independently. The DOR stated that [Resident #1] was currently transferring out of bed (oob) with supervision. The surveyor questioned the diagnosis of paraplegic if the resident was walking, and the DOR stated that [Resident #1] was a paraplegic and rehab was working with them to walk. (continued on next page)

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F 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/29/24 at 11:24 AM, the surveyor interviewed the facility's SW, who stated she had just started at the facility last week and had not gotten to speak to all the residents yet. The surveyor asked if the SW spoke with Resident #1, and she stated no, but the resident was on her list. On 8/29/24 at 11:55 AM, the surveyor interviewed the Director of Activities (DA) who stated activities were conducted in groups on both nursing units, and staff did one-to-one (1:1) activities as needed. The DA stated that 1:1 activities included providing puzzles and crossword puzzles. The surveyor asked if she provided 1:1 activities for Resident #1, and the DA stated that activity staff did not see [Resident #1] that often. The DA stated that there were two COs in there and staff were not really supposed to be in there; that she could not provide any activities, crossword puzzles, or games. The DA stated that Resident #1 requested a pack of playing cards about a month ago, and the facility was not allowed to provide, that the CF's SW had to provide. On 8/29/24 at 12:15 PM, the surveyor interviewed Resident #1's assigned CNA (CNA #1), who stated the resident provided their own care; that they were able to get out of bed and go to the bathroom by themselves, and Resident #1 was permitted out of their room to the shower room with the two COs, and the CNA provided the washcloth and towel. CNA #1 stated when [Resident #1] showered, it was just the resident in the room with the two COs. CNA #1 stated that [Resident #1] always ate all their meals in their room on disposable ware with the two COs in the room. On 8/29/24 at 12:20 PM, the surveyor interviewed LPN #1 in the presence of LPN #2, who stated that [Resident #1] received wound care for a small wound on their buttock that was more of a tunneling hole than a wound. The LPN #1 stated the wound was the width of a cotton swab, and that [Resident 31] saw a wound doctor outside the facility because they refused to see the facility's wound doctor. The LPN #1 stated that there were always two-armed COs with [Resident #1], and the only time [Resident #1] left their room was for rehab and doctor's appointments. The surveyor asked how often the resident had wound doctor appointments, and the LPN #2 stated she was unsure if there was a set schedule, but that [Resident #1] had an appointment today. The LPN #2 stated that the CF setup the transportation, and the COs accompanied Resident #1 to and from the appointment. On 8/29/24 at 12:30 PM, the surveyor observed Resident #1 sitting in a wheelchair being transported down the hallway in wrist and ankle cuffs in an orange jumpsuit with three-armed COs. The surveyor asked Resident #1 where they were going, and Resident #1 stated to see the wound doctor, that they did not want to see the doctor here. Resident #1 stated their appointment was at the hospital, and that their wound was improving. The surveyor asked Resident #1 if they ever received the playing card they requested, and Resident #1 stated no. The surveyor then observed Resident #1 with two COs (CO #2 and CO #3) and no residents or staff, use the elevator to go downstairs. At that time, the surveyor asked CO #1 why [Resident #1] needed to wear hand and ankle cuffs, since it was reported earlier that the resident did not need because they could not walk. CO #1 stated it was protocol when the JIRs left the building. The surveyor asked how [Resident #1] was transferred to the hospital, and the CO stated on a medical bus from the CF. On that same date, the surveyor observed Resident #1 being escorted out of the building by four COs. (continued on next page)

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F 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/29/24 at 12:56 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the DON, who stated that she had started at the facility on 4/11/24, and the previous owners of the facility had a contract with the CF since 2022. The LNHA stated that the JIRs were only at the facility for medical services, and when their medical treatment was completed, the JIRs returned to the CF. The LNHA stated that Resident #1 stayed in their room with the two COs and went to rehab accompanied by them. The LNHA stated that everything was controlled by the CF; that the facility could not provide playing cards; phone usage; visitors. The LNHA stated the CF's SW came to the facility she thought once a month for [Resident #1] to make a phone call, but she did not believe there was a set schedule. At that time, the DON stated that the resident informed the facility that the CF had to approve all visits, and the resident could not have a visitor unless the CF approved it. The DON stated there were no private visits, that there were always COs; and [Resident #1] could not be without them. The DON stated it was the CF's policies; that [Resident #1] could have no other clothes except their orange jumpsuit that identified them as a JIR as a safety precaution. The DON stated only [Resident #1] and the COs could be in the elevator during transportation, and that [Resident #1] saw an outside wound doctor that the appointments were scheduled by the CF. The DON stated that [Resident #1] saw the facility's Psychiatrist as needed and could have seen the facility's wound doctor but refused. The DON stated that [Resident #1] received the same level of care as all the other residents in the facility, they just did not have the freedoms. The DON stated that [Resident #1] had wrist and ankle cuffs as safety precaution that was a standard protocol by the CF, and the facility did not control that. The DON stated that the facility was in control of [Resident #1's] nursing care, and everything else was controlled by the CF. The surveyor requested a copy of the resident's admission agreement and resident rights. On 8/29/24 at 1:30 PM, the surveyor reviewed the facility's policies regarding JIRs which included the following: A review of the Inmate Resident Dining policy dated 8/21/23, included it is the policy of the [facility] to provide meals and snacks in a manner that supports establish security protocols. Procedure: 1. all inmates will receive their meals and snacks and dine in their room; 2. all inmate resident meals will be served on disposable paper goods; 3. all inmate resident meals will be served with plastic utensils; metal utensils are never permitted; 4. prior to delivery of meal tray to the inmate resident the CO in attendance will be offered the opportunity to check the tray .7. there is no food or drinks other than a water pitcher (when clinically approved) be stored at bedside . A review of the Inmate Phone Use policy dated 8/21/23, included 1. inmates are not routinely permitted to access telephones, not landlines or cell phones; 2. the landline will be removed from the inmate room prior to admission; 3. the staff is not to facilitate or participate in allowing inmates to use a telephone; 4. in rare circumstances when telephone use is permitted this will be entirely taken care of by the [CF staff], specifically the assigned COs; 5. at no time is [facility] staff to participate in inmate's phone use. A review of the Concerns with Correctional Officers policy dated 9/12/23, included that COs should be treated with dignity and respect by all staff . On 8/29/24 at 3:05 PM, the DON informed the survey team that she had spoken to the CF to have the CF inform the facility who was permitted to visit the resident and when. (continued on next page)

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F 0561 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An acceptable Removal Plan (RP) on 8/30/24 at 1:44 PM indicated the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including the resident was returned to the CF on 8/29/24; the facility ended their contract with the CF to accept JIR and has no other contracts with additional CFs to accept JIRs; the LNHA and DON were inserviced regarding CMS's S & C memo regarding JIR; and the LNHA was responsible for the implementation of all facility policies and regulations. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 8/30/24. NJAC 8:39-4.1(a)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 38080 Based on interview and review of pertinent facility documents, it was determined that the facility failed to issue the required Advance Beneficiary Notice (ABN) and Notice of Medicare Non-Coverage (NOMNC) forms prior to discharge from Medicare Part A services. This deficient practice was identified for for 3 of 3 residents reviewed for beneficiary notifications (Resident #28, #55, and #82), and was evidenced by the following: On 6/25/24 at 9:18 AM, the surveyor reviewed three residents (#28, #55, #82) who were discharged from their Medicare Part A stay with benefit days remaining within the past six months and should have received Beneficiary Notices. Resident #28 had a last documented covered day of Medicare Part A service coverage date of 4/12/24, from a facility-initiated discharge when benefit days were not exhausted. The facility did not have the resident or resident representative sign the required NOMNC form to notify them of the termination of insurance. The ABN form was also unsigned and dated 6/12/24 (two months after discharge), and only included rehabilitation (rehab) services with no documented estimated costs. The ABN form contained no other services Medicare would not cover with the estimated costs. Resident #55 had a last documented covered day of Medicare Part A service coverage date of 6/13/24, from a facility-initiated discharge when benefit days were not exhausted. The facility provided the NOMNC form for the resident to sign on 4/12/24 with a notation that the date was incorrect; it was signed on 6/21/24, which was eight days after the last covered day. The ABN form was also signed and dated 4/12/24 (two months prior to discharge), and only included rehab services with no documented estimated costs. The ABN form contained no other services Medicare would not cover with the estimated costs. Resident #82 had a last documented covered day of Medicare Part A service date of 5/31/24, with the resident discontinued from services due to non-participation. The facility provided the NOMNC form for the resident to sign on 5/29/24; which the facility noted the resident refused to sign and responsible party notified but no signature. The ABN form was unsigned and dated 5/29/24, and only included rehab services with no documented estimated costs. The ABN form contained no other services Medicare would not cover with the estimated costs. On 6/25/24 at 10:01 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated the ABN and NOMNC forms were provided to residents who received Medicare Part A services that benefit time still remained, but the services were discontinued. The NOMNC was provided forty-eight hours prior to discharge from rehab that informed the resident their right to appeal the discharge. The ABN form was also provided then, and listed what Medicare services would not be covered and the cost of those services. At that time the surveyor reviewed the residents' ABN and NOMNC forms, and the LNHA confirmed they were not completed appropriately. The LNHA stated the facility had no Social Worker (SW) since October of 2023 until about a week ago who worked ten hours a week, and usually the SW had the resident complete the forms. The LNHA continued the Rehab Department provided at that time the NOMNC forms, and she did not believe the ABN forms were being completed with no SW. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Advance Beneficiary Notices (ABN) and Notice of Medicare Non-Coverage (NOMNC) Guidelines dated last revised 1/1/24, included the facility shall obtain in a timely manner and retain all Advance Beneficiary Notices (ABN) and Notice of Medicare Non-Coverage as required by [Centers for Medicaid Medicare Services] guidelines. The [Minimum Data Set] Coordinator is responsible for monitoring and ensuring the ABN's are completed on each resident in a timely manner .ABN is issued when you expect Medicare to deny payment for an item or service because it is not reasonable and necessary under Medicare Program standards .The ABN allows the beneficiary to make an informed decision about whether to get services and accept financial responsibility for those services if Medicare does not pay .Medicare considers issuance of ABN and/or NOMNC effective when the notice is [.] provided far enough in advance of potentially non-covered items or services to allow sufficient time for the beneficiary to consider available options (at least two days) .The beneficiary or the beneficiary's representative must sign and retain the ABN and send a copy of the signed ABN to you for retention in the beneficiary's record. Keep a copy of the unsigned ABN on file while awaiting receipt of the signed ABN. If the beneficiary fails to return a signed copy, document the initial contact and subsequent attempts to obtain a signature in appropriate records or on the ABN. NJAC 8:39-5.4 (b)(c)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45209 Complaint NJ #159783 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to to maintain the residents' environment, equipment, and living areas in a safe, sanitary, and homelike manner that included clean linens and privacy curtains. This deficient practice was identified for 2 of 2 nursing units observed for the facility environment task. This deficient practice was evidenced by the following: 1. During entrance conference on 6/17/24 at 10:00 AM, the surveyor asked what the resident census in the facility was, and the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON) stated 94 residents. On 6/17/24 at 10:42 AM, during initial tour of the Second Floor nursing unit, the surveyor observed that the clean linen cart located near Resident room [ROOM NUMBER] did not contain any towels. On 6/19/24 at 11:16 AM, the surveyor toured the Second Floor nursing unit and observed no clean towels in the clean linen cart located by Resident room [ROOM NUMBER], and one clean towel in the clean linen cart by Resident room [ROOM NUMBER]. On 6/20/24 at 10:48 AM, the surveyor toured the Second Floor nursing unit and did not observe any clean towel in the clean linen cart by Resident room [ROOM NUMBER]. On 6/24/24 at 1:39 PM, the surveyor interviewed the Director of Housekeeping (DH) who stated that linens and towels were routinely processed throughout the day. The DH indicted that there was no storage area where clean towels were kept and ready for the residents. The surveyor completed an inspection of the laundry room, where it was observed that only six towels were clean. At that time, Housekeeper #1 (HK #1) entered the laundry room and stated that they were responsible for checking the clean linen carts every two hours. When asked the times in which laundry was brought to the floors, HK #1 explained that it was brought up at 7:30 AM before morning care, 1:30 PM, and about 2:30 to 3:00 PM before end of shift. When asked how many towels were brought to the floor, HK #1 reported twenty towels and twenty washcloths. The surveyor questioned if there were any issues with the stock of towels, at which time HK #1 admitted that the facility can run low because the agency nurses threw away a lot of the towels and washcloths. On 6/25/24 at 11:49 AM, the surveyor interviewed the [NAME] President of Environmental Services (VPE) who acknowledged that the DH approached them and identified that the number of towels has gone down. The VPE further confirmed that towels were a problem and that the facility had placed an order for additional towels. On 6/26/2024 at 10:35 AM, the LNHA, in the presence of the Regional Nurse, Assistant Director of Nursing (ADON), and DON, confirmed that there was not enough towels in the facility for the residents and that morning they stopped at a sister facility to pick up more towels. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44833 2. On 6/17/24 at 10:47 AM, during initial tour of the facility, the surveyor observed Resident room [ROOM NUMBER] which was occupied by four residents in beds A, B, C, and D. Bed C had a privacy curtain pulled around the bed and was observed to be soiled with a reddish/brown substance along the bottom of the curtain. On 6/20/24 at 12:55 PM, in the presence of the survey team and the LNHA, the DON, when presented with a photograph of the observed soiled privacy curtain, stated that privacy curtains were to be cleaned monthly or more frequently if needed and that it should not look like that. Review of the facility's Cleaning and disinfecting wheelchairs, gerichairs, bedside commode, and privacy curtain policy dated last reviewed March 2024, included ensure that privacy curtains are kept clean and in good repair by: Conduct daily review of all privacy curtains to identify if any. Soiling is noted. Remove and replace monthly/as need for cleaning service . A review of the facility's Resident Rights policy, created February 2024, included .The resident has a right to a safe, clean, comfortable and Homelike Environment, including but not limited to receiving treatment and supports for daily living safely . A review of the facility's undated Quality of Life- Homelike Environment policy included .2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. NJAC 8:39-31.4(a)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure all residents were free from abuse including the involuntary seclusion and use of physical restraints for a Justice Involved Resident (JIR). This deficient practice was identified for 1 of 1 JIR (Resident #1). Resident #1 was admitted to the facility on [DATE], and was secluded by Corrections Officers (CO) from the Correctional Facility (CF). Resident #1 was observed being secluded to their room, guarded by two COs; Resident #1 was not permitted to participate in group activities and community dining. Resident #1 stated hey were not allowed to leave their room; have visitors unless scheduled and approved by the CF; could not choose their own clothes having to wear an orange jumpsuit that made them feel embarrassed; participate in activities; eat all meals in their room on disposable ware; not allowed use the telephone; and had no privacy which the resident reported feeling lonely and depressed being in a room twenty-four hours a day seven days a week with two CFs and a television. Resident reported they wanted to return to the CF because of it. The facility's failure to ensure all residents, including JIR, were free from abuse including involuntary seclusion and the use of physical restraints posed a likelihood to cause serious injury and psychological harm. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 8/29/24, and the facility Administration was notified of the IJ on 8/29/24 at 4:29 PM. The facility submitted an acceptable Removal Plan (RR) on 8/30/24 at 1:44 PM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 8/30/24. The findings were as follows: Reference: The Centers for Medicare and Medicaid Services (CMS) updated Guideline to Surveyors on Federal Requirements for Providing services to Justice Involved individuals, revised 12/23/2016 S & C 16-21-ALL documented Skilled Nursing Facilities must permit residents to have autonomy and choice to the maximum extent practicable regarding how they wish to live their everyday lives and receive care with the same rights as nursing home residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belle Care Nursing and Rehabilitation Center	439 Bellevue Avenue Trenton, NJ 08618

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's Resident Rights dated revised 1/3/24, included 10. all residents will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression .Resident Rights: 1. the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility .5. the resident has the right to be treated with respect and dignity including: the right to be free from physical or chemical restraints imposed for the purpose of discipline or convenience [.] the right to retain and use personal possessions [.] the right to receive services in the facility with reasonable accommodation of resident needs and preferences [.]the right to share a room with a roommate of his/her choice [.] 6. Self-determination: the resident has the right to and the facility must 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 with members of the community; receive visitors of their choosing at the time of their choosing .participate in other activities including social, religious, and community activities .8. Privacy and confidentiality: the resident has the right to personal privacy and confidentiality of their personal and medical records .9. Safe environment: the resident has the right to a safe, clean, comfortable and homelike environment . A review of the facility's Abuse Prevention policy dated revised June 2024, included it is the policy of [facility] to not tolerate any form of resident abuse, neglect, or exploitation by staff members, volunteers, visitors or family members, or by another resident. The facility will have an abuse prevention program that protects residents from physical and mental abuse [.] in compliance with State and Federal regulations .Involuntary seclusion: the separation of a resident from other residents or from his/her room, or confinement to his/her room against resident's will or against the will of the responsible party .Resident [NAME] of Rights: as a nursing home resident in the State of New Jersey, you have the following rights:[.] Freedom from Abuse and Restraints: free from physical and mental abuse; freedom from chemical and physical restraints, unless they are authorized by a physician for a limited period of time to protect you or others from physical injury . A review of the facility provided Clinical Programs Manual Topic: Restraint Management dated effective October 2021, included restraints will be used only when necessary to treat medical symptoms and not used for staff convenience. The least restrictive restraint for the shortest duration of time will be applied to assist the resident in reaching their highest level of physical and psychosocial well-being .restraints include, but are not limited to the following: arm restraints [.] leg restraints .Guidelines: 1. evaluate care plan to ensure that restraint alternative interventions have been tried prior to consideration of the restraint .4. obtain a physician's order for restraint [.] 5. provide the Physical Restraint Information Sheet to the resident or responsible party [.] 6. review and revise the following: the care plan . A review of the facility's Visitation policy dated revised May 2024, included the facility permits residents to receive visitors subject to the resident's wishes and the protection of the rights of other residents in the facility to maintain contact with the community in which he/she lived or is familiar. Procedure: 1. the resident's family may visit the resident at any time subject to the protection of the rights and safety of other residents and any restrictions imposed by the resident .5. residents may visit with members of the clergy at any time subject to the protection of the rights of others during communicable disease outbreaks . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Belle Care Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 439 Bellevue Avenue Trenton, NJ 08618	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/29/24 at 9:45 AM, the surveyor observed a personal protective equipment (PPE) bin outside of Resident #1's room. At that time, the surveyor interviewed the Licensed Practical Nurse Supervisor (LPN Supervisor #1), who stated Resident #1 had a stage 4 pressure wound (full-thickness skin loss extends through the fascia with considerable tissue loss) to their right buttock, and when staff provided care, they needed to don (wear) additional PPE. The surveyor asked if staff had to wear PPE when Resident #1 was out of the room, and the LPN Supervisor #1 stated that [Resident #1] was a JIR who remained in their room unless to go to the rehabilitation (rehab) gym. The LPN Supervisor #1 stated that [Resident #1] did not participate in activities; ate all their meals in their room on disposable ware; wore an orange jumpsuit in therapy; visitors needed to be scheduled through the CF by appointment; and [Resident #1] always remained in the room alone with two-armed COs. 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 two-armed COs (CO #1 and CO #2) who were stationed at the resident's door (CO #1) and the resident's window (CO #2). At that time, the surveyor interviewed the resident, who stated they had been at the facility for over a year now, and they were receiving rehab and wound care at the facility. Resident #1 stated that they wanted to return to the CF; they were lonely and depressed at the facility because they remained in their room twenty-four hours a day, seven days a week with two COs and a television. Resident #1 stated they ate in their room on disposable ware and there were no activities. Resident #1 stated that they were prohibited visitors unless the CF approved the visits, and the CF was not responding to their visitors for appointments. Resident #1 stated they were waiting for grievance paperwork from the CF to complain about it, which they had not received, and the CF's Social Worker (SW) was supposed to come to the facility weekly so they could have their weekly phone call. Resident #1 stated the CF's SW maybe came to the facility twice a month, so they missed their allowed phone calls, and the resident wanted to call their attorney to request to be transferred back to the CF. Resident #1 stated they had no privacy, anytime they received care the COs were in the room, and if they had visitors or made a call, the COs were present. Resident #1 stated that when they went to rehab, they wore an orange jumpsuit which embarrassed them because it let everyone know they were a JIR. The surveyor asked if the resident had to wear any cuffs (wrist or ankle) in the room or in rehab, and the resident stated, no, they could not walk. At the time of the interview, the surveyor asked CO #1 if everything the resident reported was accurate, and the CO stated yes, the resident was incarcerated. On 8/29/24 at 10:41 AM, the surveyor reviewed the medical record for Resident #1. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; paraplegia (leg paralysis); chronic pain; depressive disorder; anxiety disorder; insomnia; and stage 4 pressure ulcer of right buttock. A review of the Progress Notes included a Nursing Note dated 4/27/23 at 7:37 AM, which included the resident was admitted to the facility on [DATE] at 6:55 PM, accompanied by two COs. The resident was admitted with a right ischial (lower buttock) pressure sore; was receiving intravenous (IV) antibiotics; and had a wound vacuum (negative pressure wound therapy treatment that uses suction to assist in wound healing). (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 7/31/24, reflected the resident had a brief interview for mental status score of 15 out of 15, indicating that the resident had an intact cognition. A further review reflected the resident had no mood or behavior issues. A review of the individual comprehensive care plan (ICCP) included the following focus areas: A focus area dated 7/3/24, revealed the resident was not permitted access to telephones, not landlines or cell phones. In the rare circumstances when phone use was permitted, the CF, not the staff take care of it. The resident was not permitted to go out on pass or out of the facility unless escorted by COs and authorized by the CF. The intervention was that the resident would be closely monitored by the CF. A focus area dated 7/3/24, indicated inmate 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 would maintain stable weight and be free from dehydration. A focus area dated 8/13/24, revealed the resident used anti-anxiety medications with regards to anxiety disorder. Interventions were to educate resident/family/caregivers about risks, benefits, and side effects and toxic symptoms; give anti-anxiety medications as ordered by physician; monitor and record occurrence of target behavior and symptoms; and increased risk of confusion, amnesia, loss of balance, falls, monitor for safety. A focus area dated 8/13/24, revealed the resident used antidepressant medication with regards to depression. Interventions included to educate the resident/family/caregivers about risks, benefits, and side effects and toxic symptoms; give antidepressant medications as ordered by physician; monitor, document, and report to physician as needed any ongoing signs and symptoms of depression. A focus area dated 8/11/24, revealed the resident had depression with regards to lifestyle changes. Interventions included to administer medications as ordered; monitor, document, and report as needed any signs and symptoms of depression; and monitor, record, and report to physician as needed the risk for harming others. A review of the Psychiatric (Psych) Follow Up Note dated 7/17/24, included resident had a history of anxiety, depression, and insomnia. The resident reported I feel stressful and felt depressed and anxious at times. The resident reported sleep disturbance and eating was okay. A review of the Psychiatric (Psych) visit dated 7/24/24, included that the resident was seen today for a follow-up visit. The resident reported I am feeling a little better, less stressful, less anxious. The resident reported feeling depressed and anxious at times with disturbed sleep, and eating was okay. A review of the Order Listing Report included the following physician's orders (PO): A PO dated 8/12/24, that the resident cannot go out on pass or out of the facility unless escorted by COs and Emergency Medical Services (EMS). (continued on next page)

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F 0603

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

A PO dated 8/13/24, for trazadone (antidepressant) 50 milligram (mg) tablet; give one tablet orally at bedtime for insomnia.

A PO dated 8/17/24, for Zoloft 50 mg tablet; give one tablet by mouth in the evening for depressive episodes.

On 8/29/24 at 11:01 AM, the surveyor interviewed the Director of Rehab (DOR), who stated Resident #1 participated in physical therapy (PT) three to five times a week in the rehab gym. The DOR stated that [Resident #1] was transferred to the rehab gym by two COs who always remained with them, and there were no other residents present. The DOR stated that [Resident #1] did not require any ankle or wrist cuffs because they were paraplegic. The DOR stated that Resident #1 was working on ambulating (walk) and transferring; that their goal was to walk in their room and use the bathroom independently. The DOR stated that [Resident #1] was currently transferring out of bed (oob) with supervision. The surveyor questioned the diagnosis of paraplegic if the resident was walking and the non-use of leg cuffs, and the DOR stated [Resident #1] was a paraplegic and rehab was working with them to walk. The DOR also stated that the use of hand and leg cuffs was the decision of the CF; that the facility could not order cuffs.

On 8/29/24 at 11:55 AM, the surveyor interviewed the Director of Activities (DA) who stated activities were conducted in groups on both nursing units, and staff did one-to-one (1:1) activities as needed. The DA stated that 1:1 activities included providing puzzles and crossword puzzles. The surveyor asked if she provided 1:1 activities for Resident #1, and the DA stated that activity staff did not see [Resident #1] that often. The DA continued that there were two COs in there and staff were not really supposed to be in there; that she could not provide any activities, crossword puzzles, or games. The DA stated [Resident #1] requested a pack of playing cards about a month ago, and the facility was not allowed to provide, that the CF's SW had to provide.

On 8/29/24 at 12:15 PM, the surveyor interviewed [Resident #1's] assigned CNA (CNA #1), who stated [Resident #1] always stayed in their room with two COs. CNA #1 stated that [Resident #1] was permitted out of their room to the shower room with the two COs, and the CNA provided the washcloth and towel. CNA #1 stated when [Resident #1] showered, it was just the resident in the room with the two COs. CNA #1 stated that [Resident #1] always ate all their meals in their room on disposable ware with the two COs in the room.

On 8/29/24 at 12:20 PM, the surveyor interviewed the LPN #1 in the presence of LPN #2, who stated that [Resident #1] received wound care for a small wound on their buttock that was more of a tunneling hole than a wound. The LPN #1 stated the wound was the width of a cotton swab, and [Resident #1] saw a wound doctor outside the facility because they refused to see the facility's wound doctor. LPN #1 stated that there were always two-armed COs with [Resident #1], and the only time [Resident #1] left their room was for rehab and doctor's appointments. The surveyor asked how often [Resident #1] had wound doctor appointments, and LPN #2 stated she was unsure if there was a set schedule, but [Resident #1] had an appointment today. LPN #2 stated that the CF setup the transportation, and the COs accompanied [Resident #1] to and from the appointment.

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/29/24 at 12:30 PM, the surveyor observed Resident #1 sitting in a wheelchair being transported down the hallway in wrist and ankle cuffs in an orange jumpsuit with three-armed COs. The surveyor asked Resident #1 where they were going, and Resident #1 stated to see the wound doctor, that they did not want to see the doctor here. Resident #1 stated their appointment was at the hospital, and that their wound was improving. The surveyor asked the resident if they ever received the playing card they requested, and Resident #1 stated no. The surveyor then observed Resident #1 with two COs (CO #2 and CO #3) and no residents or staff, use the elevator to go downstairs. At that time, the surveyor asked CO #1 why [Resident #1] needed to wear hand and ankle cuffs, since it was reported earlier that the resident did not need because they could not walk. CO #1 stated it was protocol when the JIR left the building. The surveyor asked how [Resident #1] was transferred to the hospital, and the CO stated on a medical bus from the CF. The surveyor observed Resident #1 being escorted out of the building by four COs. On 8/29/24 at 12:45 PM, the surveyor continued to review the medical record. A review of the Order Listing Report did not include a PO for the use of restraints (wrist and ankle cuffs). A review of the ICCP did include a focus area for the use of restraints. On 8/29/24 at 12:56 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the DON, who stated that she had started at the facility on 4/11/24, and the previous owners of the facility had a contract with the CF since 2022. The LNHA stated that the JIRs were only at the facility for medical services, and when their medical treatment was completed, the JIRs returned to the CF. The LNHA continued that Resident #1 stayed in their room with the two COs and went to rehab accompanied by them. The LNHA stated that everything was controlled by the CF; that the facility could not provide playing cards; phone usage; visitors. The LNHA stated the CF's SW came to the facility she thought once a month for [Resident #1] to make a phone call, but she did not believe there was a set schedule. At that time, the DON stated that [Resident #1] informed the facility that the CF had to approve all visits, and [Resident #1] could not have a visitor unless the CF approved it. The DON stated there were no private visits, that there were always COs; and [Resident #1] could not be without them. The DON stated it was the CF's policies; and [Resident #1] could have no other clothes except their orange jumpsuit that identified them as a JIR as a safety precaution. The DON stated only [Resident #1] and the COs could be in the elevator during transportation, and that [Resident #1] saw an outside wound doctor that the appointments were scheduled by the CF. The DON stated [Resident #1] saw the facility's Psychiatrist as needed and could have seen the facility's wound doctor but refused. The DON stated that Resident #1 received the same level of care as all the other residents in the facility, they just did not have the freedoms. The DON stated that [Resident #1] had wrist and ankle cuffs as safety precaution that was a standard protocol by the CF, and the facility did not control that. The DON stated that the facility was in control of [Resident #1's] nursing care, and everything else was controlled by the CF. The surveyor requested a copy of the resident's admission agreement and resident rights. On 8/29/24 at 1:30 PM, the surveyor reviewed the facility's policies regarding JIRs which included the following: (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Inmate Resident Dining policy dated 8/21/23, included it is the policy of the [facility] to provide meals and snacks in a manner that supports establish security protocols. Procedure: 1. all inmates will receive their meals and snacks and dine in their room; 2. all inmate resident meals will be served on disposable paper goods; 3. all inmate resident meals will be served with plastic utensils; metal utensils are never permitted; 4. prior to delivery of meal tray to the inmate resident the CO in attendance will be offered the opportunity to check the tray .7. there is no food or drinks other than a water pitcher (when clinically approved) be stored at bedside . A review of the Inmate Phone Use policy dated 8/21/23, included 1. inmates are not routinely permitted to access telephones, not landlines or cell phones; 2. the landline will be removed from the inmate room prior to admission; 3. the staff is not to facilitate or participate in allowing inmates to use a telephone; 4. in rare circumstances when telephone use is permitted this will be entirely taken care of by the [CF staff], specifically the assigned COs; 5. at no time is [facility] staff to participate in inmate's phone use. On 8/29/24 at 3:05 PM, the DON informed the survey team that she had spoken to the CF to have the CF inform the facility who was permitted to visit the resident and when. An acceptable Removal Plan (RP) on 8/30/24 at 1:44 PM indicated the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including the resident was returned to the CF on 8/29/24; the facility ended their contract with the CF to accept JIR and has no other contracts with additional CFs to accept JIRs; the LNHA and DON were inserviced regarding CMS's S & C memo regarding JIR; and the LNHA was responsible for the implementation of all facility policies and regulations. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 8/30/24. NJAC 8:39-4.1(a)(5)(6)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure all residents were free from abuse including the use of physical restraints imposed for the purposes of discipline or convenience for a Justice Involved Resident (JIR). This deficient practice was identified for 1 of 1 JIR (Resident #1). Resident #1 was admitted to the facility, and was secluded by Corrections Officers (CO) from the Correctional Facility (CF). Resident #1 was observed being secluded to their room, guarded by two COs, and Resident #1 was not permitted to participate in group activities and community dining. Resident #1 stated that they were not allowed to leave their room; have visitors unless scheduled and approved by the CF; participate in activities; eat all meals in their room on disposable ware; not allowed use the telephone; and had no privacy which the resident reported feeling lonely and depressed being in a room twenty-four hours a day seven days a week with two CFs and a television. Resident #1 stated they wanted to return to the CF because of it. On 8/29/24 at 12:30 PM, the surveyor observed Resident #1 being transported in a wheelchair to the elevator with three-armed COs, and the resident was being restrained with wrist and ankle cuffs. The facility's failure to ensure all residents, including the JIR, were free from abuse including the use of physical restraints posed a likelihood to cause serious injury and psychological harm. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 8/29/24, when Resident #1 was observed in the hallway with physical restraints. The facility Administration was notified of the IJ on 8/29/24 at 4:29 PM. The facility submitted an acceptable Removal Plan (RR) on 8/30/24 at 1:44 PM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 8/30/24. The findings were as follows: Reference: The Centers for Medicare and Medicaid Services (CMS) updated Guideline to Surveyors on Federal Requirements for Providing services to Justice Involved individuals, revised 12/23/2016 S & C 16-21-ALL documented Skilled Nursing Facilities must permit residents to have autonomy and choice to the maximum extent practicable regarding how they wish to live their everyday lives and receive care with the same rights as nursing home residents. A review of the facility's Resident Rights dated revised 1/3/24, included 10. all residents will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression .Resident Rights: .5. the resident has the right to be treated with respect and dignity including: the right to be free from physical or chemical restraints imposed for the purpose of discipline or convenience . (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's Abuse Prevention policy dated revised June 2024, included it is the policy of [facility] to not tolerate any form of resident abuse, neglect, or exploitation by staff members, volunteers, visitors or family members, or by another resident. The facility will have an abuse prevention program that protects residents from physical and mental abuse [.] in compliance with State and Federal regulations .Involuntary seclusion: the separation of a resident from other residents or from his/her room, or confinement to his/her room against resident's will or against the will of the responsible party .Resident [NAME] of Rights: as a nursing home resident in the State of New Jersey, you have the following rights:[.] Freedom from Abuse and Restraints: free from physical and mental abuse; freedom from chemical and physical restraints, unless they are authorized by a physician for a limited period of time to protect you or others from physical injury . A review of the facility provided Clinical Programs Manual Topic: Restraint Management dated effective October 2021, included restraints will be used only when necessary to treat medical symptoms and not used for staff convenience. The least restrictive restraint for the shortest duration of time will be applied to assist the resident in reaching their highest level of physical and psychosocial well-being .restraints include, but are not limited to the following: arm restraints [.] leg restraints .Guidelines: 1. evaluate care plan to ensure that restraint alternative interventions have been tried prior to consideration of the restraint .4. obtain a physician's order for restraint [.] 5. provide the Physical Restraint Information Sheet to the resident or responsible party [.] 6. review and revise the following: the care plan . On 8/29/24 at 9:45 AM, the surveyor observed a personal protective equipment (PPE) bin outside of Resident #1's room. At that time, the surveyor interviewed the Licensed Practical Nurse Supervisor (LPN Supervisor #1), who stated [Resident #1] had a stage 4 pressure wound (full-thickness skin loss extends through the fascia with considerable tissue loss) to their right buttock, and when staff provided care, they needed to don (wear) additional PPE. The surveyor asked if staff had to wear PPE when the resident was out of the room, and the LPN Supervisor #1 stated that [Resident #1] was a JIR who remained in their room alone with two-armed COs, unless to go to the rehabilitation (rehab) gym. On 8/29/24 at 9:55 AM, the surveyor observed Resident #1 lying in bed with two-armed COs (CO #1 and CO #2) who stationed at the resident's door (CO #1) and the resident's window (CO #2). At that time, the surveyor interviewed Resident #1, who stated they had been at the facility for over a year now, and they were receiving rehab and wound care at the facility. Resident #1 stated that they wanted to return to the CF; they were lonely and depressed at the facility because they remained in their room twenty-four hours a day, seven days a week with two COs and a television. Resident #1 stated they ate in their room on disposable ware and there were no activities. Resident #1 stated that they were prohibited visitors unless the CF approved the visits, and the CF was not responding to their visitors for appointments. Resident #1 stated they were waiting for grievance paperwork from the CF to complain about it, which they had not received, and the CF's Social Worker (SW) was supposed to come to the facility weekly so they could have their weekly phone call. Resident #1 stated the CF's SW maybe came to the facility twice a month, so they missed their allowed phone calls, and the resident wanted to call their attorney to request to be transferred back to the CF. Resident #1 stated they had no privacy, anytime they received care the COs were in the room, and if they had visitors or made a call, the COs were present. Resident #1 stated that when they went to rehab, they wore an orange jumpsuit which embarrassed them because it let everyone know they were a JIR. The surveyor asked if [Resident #1] had to wear any cuffs (wrist or ankle) in the room or in rehab, and the resident stated, no, they could not walk. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Belle Care Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 439 Bellevue Avenue Trenton, NJ 08618	

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At the time of the interview, the surveyor asked CO #1 if everything the resident reported was accurate, and the CO stated yes, the resident was incarcerated. On 8/29/24 at 10:41 AM, the surveyor reviewed the medical record for Resident #1. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; paraplegia (leg paralysis); chronic pain; depressive disorder; anxiety disorder; insomnia; and stage 4 pressure ulcer of right buttock. A review of the Progress Notes included a Nursing Note dated 4/27/23 at 7:37 AM, which included the resident was admitted to the facility on [DATE] at 6:55 PM, accompanied by two COs. The resident was admitted with a right ischial (lower buttock) pressure sore; was receiving intravenous (IV) antibiotics; and had a wound vacuum (negative pressure wound therapy treatment that uses suction to assist in wound healing). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 7/31/24, reflected the resident had a brief interview for mental status score of 15 out of 15, indicating that the resident had an intact cognition. A further review reflected the resident had no mood or behavior issues. A review of the individual comprehensive care plan (ICCP) included the following focus areas: A focus area dated 7/3/24, revealed the resident was not permitted access to telephones, not landlines or cell phones. In the rare circumstances when phone use was permitted, the CF, not the staff take care of it. The resident was not permitted to go out on pass or out of the facility unless escorted by COs and authorized by the CF. The intervention was that the resident would be closely monitored by the CF. A focus area dated 7/3/24, indicated inmate 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 would maintain stable weight and be free from dehydration. A focus area dated 8/11/24, revealed the resident had depression with regards to lifestyle changes. Interventions included to administer medications as ordered; monitor, document, and report as needed any signs and symptoms of depression; and monitor, record, and report to physician as needed the risk for harming others. A review of the Psychiatric (Psych) Follow Up Note dated 7/17/24, included resident had a history of anxiety, depression, and insomnia. The resident reported I feel stressful and felt depressed and anxious at times. The resident reported sleep disturbance and eating was okay. A review of the Psychiatric (Psych) visit dated 7/24/24, included that the resident was seen today for a follow-up visit. The resident reported I am feeling a little better, less stressful, less anxious. The resident reported feeling depressed and anxious at times with disturbed sleep, and eating was okay. A review of the Order Listing Report included the following physician's orders (PO): (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A PO dated 8/12/24, that the resident cannot go out on pass or out of the facility unless escorted by COs and Emergency Medical Services (EMS). On 8/29/24 at 11:01 AM, the surveyor interviewed the Director of Rehab (DOR), who stated Resident #1 participated in physical therapy (PT) three to five times a week in the rehab gym. The DOR stated that [Resident #1] was transferred to the rehab gym by two COs who always remained with them, and there were no other residents present. The DOR stated that [Resident #1] did not require any ankle or wrist cuffs because they were paraplegic. The DOR stated that Resident #1 was working on ambulating (walk) and transferring; that their goal was to walk in their room and use the bathroom independently. The DOR stated that [Resident #1] was currently transferring out of bed (oob) with supervision. The DOR also stated that the use of hand and leg cuffs was the decision of the CF; that the facility could not order cuffs. On 8/29/24 at 12:20 PM, the surveyor interviewed the LPN #1 in the presence of LPN #2, who stated that [Resident #1] received wound care for a small wound on their buttock that was more of a tunneling hole than a wound. LPN #1 stated the wound was the width of a cotton swab, and [Resident #1] saw a wound doctor outside the facility because they refused to see the facility's wound doctor. The LPN #1 stated that there were always two-armed COs with [Resident #1], and the only time [Resident #1] left their room was for rehab and doctor's appointments. The surveyor asked how often the resident had wound doctor appointments, and the LPN #2 stated she was unsure if there was a set schedule, but that [Resident #1] had an appointment today. The LPN #2 stated that the CF setup the transportation, and the COs accompanied [Resident #1] to and from the appointment. On 8/29/24 at 12:30 PM, the surveyor observed Resident #1 sitting in a wheelchair being transported down the hallway in wrist and ankle cuffs in an orange jumpsuit with three-armed COs. The surveyor asked Resident #1 where they were going, and Resident #1 stated to see the wound doctor, that they did not want to see the doctor here. Resident #1 stated their appointment was at the hospital, and that their wound was improving. The surveyor then observed Resident #1 with two COs (CO #2 and CO #3) and no residents or staff, use the elevator to go downstairs. At that time, the surveyor asked CO #1 why [Resident #1] needed to wear hand and ankle cuffs, since it was reported earlier that the resident did not need because they could not walk. CO #1 stated it was protocol when the JIR left the building. The surveyor asked how [Resident #1] was transferred to the hospital, and the CO stated on a medical bus from the CF. The surveyor observed Resident #1 being escorted out of the building by four COs. On 8/29/24 at 12:45 PM, the surveyor continued to review the medical record. A review of the Order Listing Report did not include a PO for the use of restraints (wrist and ankle cuffs). A review of the ICCP did include a focus area for the use of restraints. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/29/24 at 12:56 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the DON, who stated that she had started at the facility on 4/11/24, and the previous owners of the facility had a contract with the CF since 2022. The LNHA stated that the JIRs were only at the facility for medical services, and when their medical treatment was completed, the JIRs returned to the CF. The LNHA stated that [Resident #1] stayed in their room with the two COs and went to rehab accompanied by them. The LNHA stated that everything was controlled by the CF. At that time, the DON stated that [Resident #1] had wrist and ankle cuffs as safety precaution that was a standard protocol by the CF, and the facility did not control that. The DON stated it was the COs and not facility staff using the restraints. The DON stated that the facility was in control of [Resident #1's] nursing care, and everything else was controlled by the CF. The DON stated that [Resident #1] received the same level of care as all the other residents in the facility, they just did not have the freedoms. An acceptable Removal Plan (RP) on 8/30/24 at 1:44 PM indicated the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including the resident was returned to the CF on 8/29/24; the facility ended their contract with the CF to accept JIR and has no other contracts with additional CFs to accept JIRs; the LNHA and DON were inserviced regarding CMS's S & C memo regarding JIR; and the LNHA was responsible for the implementation of all facility policies and regulations. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 8/30/24. NJAC 8:39-4.1(a)(5)(6)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 49094 Based on interview, review of facility policy, and review of pertinent facility documents, it was determined that the facility failed to implement their abuse policy to a.) complete criminal background checks on employees prior to employment; b.) to complete reference checks on employees before their start date; and c.) to complete license checks on employees prior to their start date. The deficient practice was identified for 2 of 10 employees reviewed for new hires (Employee #9 and Employee #10), and was evidenced by the following: A review of facility's undated Abuse Policy included in the section titled Screening Components that it is the policy of this facility to screen employees and volunteers prior to working with residents. Screening components include verification of references, certification and verification of license and criminal background check .Employee Screening and Training a. Before new employees are permitted to work with residents, references provided by the prospective employee will be verified as well as appropriate board registrations and certifications regarding the prospective employee's background .d. Criminal background check will be conducted on all prospective employees as provided by the facility's policy in criminal background check . On 6/20/24 at 12:47 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) ten employee files hired since last standard survey who were currently employed or terminated from the facility. The files include both their personnel and medical. A review of employee personnel files revealed the following: For Employee #9, a registered nurse with a start date of 2/2/23, there was no evidence of a reference check prior to the start of employment. For Employee #10, an administrator with a start date of 1/30/23, there was no evidence of a license check, reference check, or criminal background check prior to the start of employment. On 6/25/24 at 12:57 PM, the surveyor interviewed the Human Resources Director (HRD) about the facility's screening process for new hires, and the HRD stated the facility completed criminal background checks prior to their first day of employment to ensure no one had a criminal history to put our residents at risk for harm. The HRD stated the facility also completed reference and license checks prior to the first day of employment. On 6/26/24 at 10:35 AM, the LNHA in the presence of the Director of Nursing (DON), Assistant Director of Nursing (ADON), and survey team acknowledged the missing pre-employment checks. The LNHA who confirmed every employee should have a criminal background and reference check prior to employment. NJAC 8:39-4.1(a)(5); 9.3(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34033 Based on observation, interview, and record review, it was determined that the facility failed to accurately assess a resident's status in the Minimum Data Set (MDS), an assessment tool used to evaluate resident's care needs. This deficient practice was identified for 5 of 35 residents reviewed for accuracy of assessments (Resident #29, #60, #73, #80, and #96), and was previously cited during the facility's last standard survey on 10/20/22. The evidence was as follows: Refer F865 1. On 6/17/24 at 10:57 AM, the surveyor observed Resident #29 sitting on their bed. The surveyor attempted to interview the resident, but the resident was unable to verbally be understood. The surveyor reviewed the medical record for Resident #29. A review of the Admission Record face sheet (admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to schizophrenia, A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 5/11/24, reflected a brief interview for mental status (BIMS) score of 5 out of 15, indicating that the resident had a severely impaired cognition. In addition, in Section A: Identification Information indicated that the resident was not considered by the state level II Preadmission Screening and Resident Review (PASARR II) process to have serious mental illness and/or intellectual disability or a related condition. A review of a level I PASARR dated 3/12/2020, that was in the paper medical record, indicated that the resident had a positive screen for mental illness and that a PASARR II was recommended. In addition, a review of a level II PASARR dated 3/12/2020, that was in the paper medical record, indicated that it was completed. On 6/20/24 at 12:54 PM, the surveyor interviewed the MDS Coordinator via the phone who stated that he had started as the MDS Coordinator in March of 2024, acknowledged that Section A of the MDS for Resident # 29 was inaccurate and he had to complete a modification to correct the 5/11/24 MDS. The MDS Coordinator added that the facility had changed computer systems and that there were inaccuracies in the transfer. On 6/20/24 at 9:30 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) who both acknowledged that the MDS for Resident #29 was inaccurate. On 6/20/24 at 12:55 PM, the survey team met with the LNHA and DON, and the DON stated that the previous MDS Coordinator resigned approximately six months ago, and the current MDS Coordinator started in March 2024, and had been working to upload from the previous computer system and paper versions to the current computer system. 45209 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 6/17/24 at 10:27 AM, the surveyor observed Resident #60 in their room watching television. Resident #60 stated that they were waiting to go outside to smoke (cigarettes). On 6/19/24 at 10:27 AM, the surveyor observed Resident #60 outside smoking cigarettes. On 6/20/2024 at 9:22 AM, the surveyor observed Resident #60 outside smoking cigarettes. The surveyor reviewed the medical record for Resident #60. A review of the Admission Record face sheet (an admission summary) reflected that Resident #60 was admitted to the facility with diagnosis that included, but not limited to hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one entire side of the body) following cerebral infarction (stroke) affecting left dominant side, candidiasis (fungal infection) of skin and nail, and bipolar disorder. A review of the most recent quarterly MDS dated [DATE], reflected the resident had a BIMS score of 12 out of 15, which indicated a moderately impaired cognition. Section J of the most recent comprehensive MDS assessment failed to identify Resident #60 as a current tobacco user. On 6/20/24 at 12:11 PM, the survey team interviewed the MDS Coordinator via telephone, who identified that the MDS department was haphazard when they arrived and has been attempting to clean it up since arriving in April. The MDS Coordinator acknowledged that they were aware of Resident #60's smoking habit, and confirmed that the MDS was coded incorrectly. On 6/25/24 at 1:30 PM, the DON, in the presence of the LNHA, Regional Nurse and Assistant Director of Nursing (ADON), and and survey team acknowledged that Resident #60's MDS was coded incorrectly. 3. On 6/19/24 at 10:01 AM, the surveyor observed Resident #73 in their room. Resident #73 explained that they had issues with bladder incontinence and urinated on the floor because I can't hold it. The surveyor reviewed the medical record for Resident #73: A review of the Order Summary Report revealed that Resident #73 was admitted to the facility with diagnosis that included, but not limited to diabetes mellitus, mood disorder, and hypertension (high blood pressure). A review of the most recent quarterly MDS dated [DATE], reflected the resident had a BIMS score of 12 out of 15, which indicated a moderately impaired cognition. In addition, Section H (Bowel and Bladder) of the MDS identified Resident #73 as continent of bladder. A review of the individualized comprehensive care plan (ICCP) included a focus area dated 10/11/23, for activities of daily living (ADL) Functional/Rehabilitation Potential. Interventions included: I will have all my needs met. In addition, another focus area, dated 10/25/22, for Elimination for incontinence as evidenced by: frequent incontinence of bladder. On 6/19/24 at 10:20 AM, the surveyor interviewed Certified Nursing Assistant (CNA #1 and #2), who both confirmed that Resident #73 unable to hold their urine, and was being changed almost daily due to the incontinence. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/20/24 at 11:23 AM, the surveyor interviewed Unit Manager/Licensed Practical Nurse (UM/LPN #1) who identified Resident #73 as incontinent. On 6/20/24 at 7:50 AM, the surveyor interviewed the MDS Coordinator who acknowledged that they are aware of Resident #73 and confirmed that the MDS should not be coded as continent of bladder. The RAI manual, version 1.18.11, October 2023, Page H-8 provided the following guidance for coding this question, Review the medical record for bladder or incontinence records or flow sheets, nursing assessments and progress notes, physician history, and physical examination. 2. Interview the resident if they are capable of reliably reporting their continence. Speak with family members or significant others if the resident is not able to report on continence. 3. Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes. 48964 4. The surveyor reviewed the closed medical record for Resident #96. A review of the Admission Record face sheet indicated that the resident was admitted to the facility with diagnosis that included but not limited to a tracheostomy (a surgically created opening in the neck to allow breathing). A review the comprehensive MDS dated [DATE], indicated in Section O, question F1 Invasive Mechanical Ventilator (a machine that supports or replaces a person's breathing) was coded as in use while a resident. A review of the medical record included no indication that Resident #96 was on a ventilator. On 6/19/24 at 11:35 AM, the surveyor interviewed the MDS Coordinator who confirmed that Resident #96 was not on a ventilator while in the facility and that the assessment was not coded correctly. On 6/20/24 at 9:30 AM, the survey team met with the LNHA and DON who both acknowledged that the MDS for Resident #96 was inaccurate. The RAI manual, version 1.18.11, October 2023, Page O-5 provided the following guidance for coding this question Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) unable to support their own respiration in this item. During invasive mechanical ventilation the resident's breathing is controlled by the ventilator. 49094 5. On 6/17/24 at 10:52 AM, the surveyor observed Resident #80 lying in bed receiving humidified oxygen at 3 liters per minute (lpm) via nasal cannula (tubing that delivers oxygen through the nose). The surveyor reviewed the medical record for Resident ##80. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Admission Record face sheet reflected the resident was admitted to facility with diagnoses which included chronic obstructive pulmonary disease (COPD; refers to a group of diseases that cause airflow blockage and breathing-related problems), morbid obesity (having too much body fat, which increases the risk of health problems) and anemia (low levels of healthy red blood cells to carry oxygen throughout your body). A review of the most recent MDS dated [DATE], reflected the resident had a BIMS score of 15 out of 15; indicating a fully intact cognition. A review of Section I, included the resident had an active diagnoses for COPD, and Section O, did not include that the resident received oxygen therapy while a resident. A review of the Physician Orders with active orders as of 6/12/24, included a physician order to administer oxygen at 3 lpm via nasal cannula as needed for shortness of breath if oxygen saturation was below 92. On 6/20/24 at 12:16 PM, the surveyor interviewed the MDS Coordinator via the phone who acknowledged that Section O of the MDS for Resident # 80 was inaccurate and should have been coded for intermittent oxygen. The MDS Coordinator added that the facility had changed computer systems and that there were inaccuracies in the transfer. On 6/20/24 at 9:30 AM, the survey team met with the LNHA and DON who both acknowledged that the MDS for Resident #80 was inaccurate. A review of facility provided policy Completion of MDS reviewed 04-2023 indicated that: The RN MDS Coordinator is responsible for ensuring the completion of the MDS. This policy also indicated that Section O is to be completed by Nursing/Therapy Dept. A review of facility's Resident Assessment Instrument (RAI) Process policy dated reviewed April 2023, included the Clinical Reimbursement Manager will oversee that the Interdisciplinary Team will complete an assessment of each resident as part of the Resident Assessment Instrument (RAI) process to assure data accuracy for the State-specific version of the Minimum Data Set (MDS) within the required timeframes according to applicable laws and regulations . NJAC 8:39-11.2(e)1; 27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45209 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to develop and implement an individualized comprehensive care plan (ICCP) consistent with the resident's history of sex offenses. This deficient practice was identified for 1 of 35 residents reviewed for care planning (Resident #73), and was evidenced by the following: On 6/19/24 at 10:01 AM, the surveyor observed Resident #73 in their room. On 6/20/24 at 11:23 AM, the surveyor interviewed the Registered Nurse (RN) who stated an ICCP was a picture of the resident and explained what needed to be done or expected for the resident. The RN confirmed that a resident's behavior or ongoing behavior patterns should be identified on the ICCP. On 6/25/24 at 9:43 AM, the surveyor interviewed the Director of Nursing (DON) regarding Resident #73's needs, and the DON identified Resident #73 as a registered sex offender. The surveyor reviewed the medical record for Resident #73. A review of the Order Summary Report revealed that Resident #73 was admitted to the facility with diagnosis that included, but not limited to diabetes mellitus, mood disorder, and hypertension (high blood pressure). The ICCP did not include a focus area identifying the resident's history as being a sex offender. On 6/25/24 at 1:30 PM, the DON, in the presence of the Licensed Nursing Home Administrator (LNHA), Regional Nurse, Assistant Director of Nursing (ADON), and survey team acknowledged that Resident #73's ICCP should have identified them as a registered sex offender. A review of the facility's undated Care Plan policy included that all residents admitted to the facility will have adequate person centered care plans that provide for all their needs in a timely manner .Procedure [.] 2. They will include initial goals, [physician's orders] orders, medications, treatments, dietary orders, therapy orders, social services, and PASARR recommendations .11. Care plans will be updated timely and necessary revisions will be made . NJAC 8:39-31.2(e)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Belle Care Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 439 Bellevue Avenue Trenton, NJ 08618	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45209 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to revise an individualized comprehensive care plan (ICCP) in a timely manner for a resident whose orthotic was discontinued. This deficient practice was identified for 1 of 35 residents reviewed for comprehensive care plans (Resident #60), and was evidenced by the following: On 6/17/24 at 10:27 AM, the surveyor observed Resident #60 in their room watching television. The resident was not observed wearing any orthotics to lower extremities. The surveyor reviewed the medical record for Resident #60. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnosis that included, but not limited to hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one entire side of the body) following cerebral infarction (stroke) affecting left dominant side, candidiasis (fungal infection) of skin and nail, and bipolar disorder. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 4/16/24, reflected a brief interview for mental status (BIMS) score of 12 out of 15, which indicated a moderately impaired cognition. A review of the ICCP included a focus area dated 7/13/22, for activities of daily living (ADL) Functional/Rehabilitation Potential. Interventions included to apply left ankle foot orthotic (AFO), a brace, when out of bed. Further review of the ICCP identified the following note with a creation date of 10/19/23: Resident use left AFO in the morning and must remove prior going to bed at night. A review of the Order Summary Report reflected an active order, dated 6/4/24, for left AFO to prevent food drop every day shift and left AFO to prevent foot drop every evening shift. On 6/25/024 at 9:43 AM, the surveyor and Director of Nursing (DON) passed Resident #60 in the hallway. The surveyor inquired if Resident #60 was currently wearing a left AFO. The DON denied and Resident #60 stated that they had not had it in while. On 6/25/24 at 10:22 AM, the surveyor interviewed the Director of Rehabilitation (DOR) regarding Resident #60's AFO physician order, who stated that the AFO was discharged on [DATE] at 4:51 PM. The DOR provided the following order: Physical Therapy Other Left AFO splint discharge order: resident was refusing to use left AFO because [they] feel uncomfortable while using it; and splint was adjusted by orthotist, but refused to use it On 6/26/24 at 10:35 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the Regional Nurse and Assistant Director of Nursing (ADON), DON, and survey team acknowledged that the order was discontinued but was still identified on the ICCP. (continued on next page)

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Belle Care Nursing and Rehabilitation Center	439 Bellevue Avenue Trenton, NJ 08618

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated Care Plan policy included all residents admitted to the facility will have adequate person centered care plans that provide for all their needs in a timely manner .Procedure [.] 2. They will include initial goals, MD orders, medications, treatments, dietary orders, therapy orders, social services, and PASARR recommendations .11. Care plans will be updated timely and necessary revisions will be made . NJAC 8:39-27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 38080 Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) administer multiple medications on multiple dates and times on a timely basis in November of 2022, and b.) ensure a discontinued physician's order was removed from active orders in accordance with professional standards of practices. This deficient practice was identified for 4 of 4 residents reviewed for medication administration times (Resident #32, #43, #60, and #250) and 1 of 24 residents reviewed for professional standards of practice (Resident #60). Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The deficient practice was evidenced by the following: 1. During entrance conference on 6/17/24 at 10:00 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) how the facility's staff was, and the LNHA stated that the facility relied heavily on Agency staffing. At that time, the surveyor requested the Nurse Staffing Report to be completed for the weeks of 11/6/22 to 11/19/22. On 6/18/24 at 11:56 AM, the LNHA informed the surveyor that the facility did not have the staffing records for 2022; that they were trying to get the information from the payroll company. The surveyor asked the LNHA if the facility needed to maintain staffing records, and the LNHA confirmed the facility should have the records. On 6/25/24 at 10:13 AM, the surveyor reviewed the Nurse Staffing Report sheets completed by the facility for 11/6/22 through 11/19/22 which revealed the facility had zero to four nurses scheduled daily in a twenty-four hour period. At that time, the LNHA stated that the facility could not locate the November 2022 staffing sheets, and they used payroll documents to complete the staffing report. The LNHA stated the facility relied heavily on Agency staff who were not included in those reports. On 6/25/24 at 10:17 AM, the surveyor interviewed the Staffing Coordinator in the presence of the LNHA who stated she was not here at the time, and could not locate the staffing sheets for that time. The Staffing Coordinator stated she could reach out to the Agencies to determine the staff provided. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belle Care Nursing and Rehabilitation Center	439 Bellevue Avenue Trenton, NJ 08618

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/24 at 10:21 AM, the surveyor interviewed the DON in the presence of the LNHA and Staffing Coordinator who acknowledged the staffing sheets needed to be maintained and kept as a reference at all times. The DON stated the unit managers kept records of the assignment sheets, but the sheets cannot be located. The DON 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 11/6/22 through 11/19/22. On 6/25/24 at 12:30 PM, the LNHA provided the surveyor with Administration Documentation Audit Detail Report (ADADR) for the weeks of 11/1/22 to 11/13/22 for Resident #32, #60, and #250. The LNHA stated Resident #252 was discharged from the facility in July of 2022, and Resident #43 was out of the facility at the time, so she provided the week of 11/25/24. On 6/25/24 at 1:30 PM, the surveyor interviewed the DON who stated medication should be administered as ordered; the right person, medication, dose, route, and time. The DON continued medication was to be administered at the time prescribed or one hour before or after the medication was timed for. The surveyor reviewed the ADADR reports provided which revealed the following: For the weeks of 11/1/22 through 11/13/22: For Resident #32, their medications were administered out of the time parameters: for the 8:00 AM dose on 11/2/22, 11/3/22, 11/4/22, 11/5/22, 11/6/22, 11/7/22, 11/10/22, 11/11/22, 11/12/22, and 11/13/22; for the 9:00 AM doses on 11/4/22, 11/5/22, 11/11/22, and 11/12/22; for the 12:00 PM doses on 11/2/22, 11/3/22, 11/4/22, 11/8/22, 11/10/22, and 11/11/22; for the 5:00 PM doses on 11/2/22, 11/3/22, 11/4/22, and 11/11/22; for the 6:00 PM dose on 11/2/22; and the 10 PM dose on 11/11/22. It was documented the resident's tube feeding (nutrition administered through a surgical tube into the stomach) scheduled at 4:00 PM, was administered late on 11/3/22, 11/7/22, 11/8/22, 11/9/22, 11/11/22, and 11/12/22. It was also documented on 11/4/22, that their 8:00 AM medications were administered at 2:04 PM; and their 11/11/22 8:00 AM and 9:00 AM medications were administered at 1:26 PM. For Resident #60, their medications were administered out of the time parameters: for the 8:00 AM doses on 11/1/22; 11/2/22; 11/3/22; 11/4/22; 11/5/22; 11/6/22; 11/7/22, 11/9/22, 11/11/22, 11/12/22, and 11/13/22; for the 9:00 AM doses on 11/1/22, 11/4/22, 11/5/22, and 11/12/22 for the 1:00 PM doses on 11/1/22, 11/2/22, 11/3/22, 11/4/22, 11/7/22, 11/8/22, and 11/11/22; for the 5:00 PM doses on 11/2/22, 11/3/22, 11/4/22, 11/7/22, 11/11/22, and 11/12/22; and the 9:00 PM doses on 11/2/22, 11/11/22, 11/12/22, and 11/13/22. It was documented that they received their 11/4/22 9:00 AM medications at 2:18 PM. For Resident #250, their medications were administered out of the time parameters: for the 8:00 AM dose on 11/11/22; for the 9:00 AM doses on 11/3/22, 11/8/22, 11/9/22, 11/11/22, 11/12/22, and 11/13/22; for the 1:00 PM doses on 11/9/22, 11/10/22, and 11/13/22; and the 5:00 PM doses on 11/3/22, 11/4/22, 11/5/22, and 11/8/22. It was documented the resident's 9:00 AM doses on 11/3/22 were administered at 1:52 PM, and their 5:00 PM doses on 11/5/22 were administered at 10:26 PM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belle Care Nursing and Rehabilitation Center	439 Bellevue Avenue Trenton, NJ 08618

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

For the week of 11/25/22 through 11/30/22, Resident #43's medications were administered out of the time parameters: for the 9:00 AM dose on 11/29/22; the 5:00 PM dose on 11/27/22; and the 6:00 PM dose on 11/27/22. It was documented the 9:00 AM medications were administered at 12:06 PM on 11/29/22.

On 6/26/24 at 10:34 AM, the LNHA acknowledged these concerns.

A review of the facility's Medication Administration Policy dated effective 12/23/23, included medications are administered in a timely fashion as specified by policy .

45209

2. On 6/17/24 at 10:27 AM, the surveyor observed Resident #60 in their room watching television. Resident #60 was observed without any orthotic to lower extremities, specifically a left ankle foot orthosis [brace] (AFO).

The surveyor reviewed the medical record for Resident #60.

A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnosis that included, but not limited to hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one entire side of the body) following cerebral infarction (stroke) affecting left dominant side, candidiasis (fungal infection) of skin and nail, and bipolar disorder.

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 4/16/24, reflected a brief interview for mental status (BIMS) score of 12 out of 15, which indicated a moderately impaired cognition.

A review of the Order Summary Report reflected an active order, dated 6/4/24, for left AFO to prevent food drop every day shift and left AFO to prevent foot drop every evening shift.

A review of the individualized comprehensive care plan (ICCP) included a focus area dated 7/13/22, for activities of daily living (ADL) Functional/Rehabilitation Potential with interventions that included to apply left AFO when out of bed. Further review of the ICCP identified the following note with a creation date of 10/19/23: Resident use left AFO in the morning and must remove prior going to bed at night.

On 6/20/24 at 11:55 AM, the surveyor observed Resident #60 without a left AFO applied.

On 6/25/24 at 9:43 AM, the surveyor and Director of Nursing (DON) passed Resident #60 in the hallway. The surveyor inquired if Resident #60 was currently wearing a left AFO, and the DON denied. Resident #60 stated that they had not had it in while.

The surveyor and the DON reviewed the electronic medical record for Resident #60, which revealed an active order to apply left AFO to prevent foot drop everyday shift, and apply left AFO to prevent foot drop every evening shift. The surveyor and DON identified that the Treatment Administration Order also that displayed the nurses initials identifying that the AFO has been applied today and within the past survey dates (6/17/24 to present). The DON confirmed that nurses should not be signing off on the order if it was not applied.

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NAME OF PROVIDER OR SUPPLIER: Belle Care Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 439 Bellevue Avenue Trenton, NJ 08618	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/24 at 11:06 AM, the surveyor interviewed the Director of Rehabilitation (DOR) who reported that the AFO was discontinued on 9/25/23 at 4:51 PM. The DOR provided a copy of the order that identified the order as signed off by the physician on 10/30/23 at 1:22 PM. On 6/26/24 at 10:35 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the DON, Regional Nurse, Assistant Director of Nursing (ADON), and survey team confirmed that Resident #60's AFO should have been discontinued in the system and that the nurses were identifying the AFO was applied when it was not. The facility could not provide any policy regarding discontinuation of physician's orders and/or accuracy of completing the treatment administration orders. NJAC 8:39-11.2(b); 27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Complaint #: NJ 159451 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a.) incontinence care was provided for 2 out of 7 residents observed during incontinence rounds (Resident #32 and Resident #147) and b.) nail care was provided during activities of daily living (ADLs) for residents 2 of 4 residents reviewed for ADLs (Resident #60 and Resident #73). This deficient practice was evidenced by the following: Refer F725 1. According to the Admission Record (AR), Resident #147 was admitted to the facility with the diagnoses which included but not limited to chronic respiratory failure and tracheostomy (hole in the windpipe to facilitate breathing). The comprehensive Minimum Data Set (MDS), an assessment tool dated 4/10/24, reflected that Resident #147 had moderate cognitive deficits and was dependent on staff for hygiene. Resident #147's individualized comprehensive care plan (ICCP) reflected that the resident required total dependence and one-person physical assistance with personal hygiene. According to the AR, Resident #32 was admitted to the facility with the diagnoses which included but not limited to cerebral infarction (stroke). The comprehensive MDS dated [DATE], reflected that Resident #32 had severe cognitive deficits and was dependent on staff for hygiene. Resident #32's ICCP reflected that the staff provided the resident incontinent care every two to four hours, and that the resident required total dependence and one-person physical assistance with personal hygiene. On 6/18/24 at 8:02 AM, the surveyor conducted an incontinence tour on the Second Floor nursing unit accompanied by the Unit Manager/Licensed Practical Nurse (UM/LPN #1) and observed the following: The surveyor and UM/LPN #1 entered Resident #147's room who was observed lying in bed. UM/LPN #1 asked the resident if she could check their incontinent brief and the resident gave UM/LPN #1 permission. The surveyor observed that the resident's incontinent brief was dry and the chuck (protective bed pad) that was directly under the resident was dry, however the fitted sheet located under the chuck had a large brown/yellow stain that smelled like urine and contained some dry brown stains which UM/LPN #1 identified as bowel movement (bm). UM/LPN #1 was interviewed at this time and stated that the Certified Nursing Assistant (CNA) that was assigned to care for Resident #32 should have changed the resident's sheet when performing incontinence care and should not have left a urine-soaked sheet on the resident's bed. UM/LPN #1 stated that the agency CNA that cared for the resident on the 11:00 PM to 7:00 AM shift must have left the dirty sheet on the resident's bed, because the CNA (CNA #1) that came in this morning just got to the unit and had not made rounds yet. UM/LPN #1 stated that incontinence rounds should be done by the CNA every two hours. The surveyor observed the resident's skin during the tour and the resident's skin was free of skin breakdown. On 6/18/24 at 8:45 AM, the surveyor conducted an incontinence tour on the First Floor nursing unit with a Licensed Practical Nurse (LPN #1) and observed the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:00 AM, the surveyor accompanied LPN #1 entered Resident #32's room observed the resident lying in bed and the resident was non-verbal. The resident's brief was observed to be very wet with urine and the sheets were observed with a large urine stain that had a strong smell of urine. LPN #1 was interviewed at the time and confirmed that the stain the surveyor observed on the resident's sheet was urine, and that the resident's incontinence brief and the entire bed linen should have been changed. The resident's skin was observed, and the resident's skin was intact and free of breakdown. On 6/18/24 at 9:10 AM, the surveyor interviewed UM/LPN #2 for the First Floor nursing unit who stated that the CNA (CNA #2) who was assigned to care for Resident #32 should have made rounds that morning when she had arrived to the unit and checked the residents to see if any residents were incontinent and needed to be changed right away. UM/LPN #2 could not speak to why Resident #32 was wet including the resident's bed linens. She stated that it was import to ensure that residents were clean and dry to protect their skin and to keep the residents comfortable. On 6/18/24 at 9:20 AM, the surveyor interviewed CNA #2 who stated that she made rounds that morning and performed an incontinence check for Resident #32. CNA #2 stated that she conducted rounds on Resident #32 in the dark, and did not see the large urine stain on the resident's bed sheets or notice the resident's brief was soaked with urine. CNA #2 stated that the resident's brief and bed linen should have been changed and that it must have been an oversight. On 6/19/24 at 9:08 AM, the surveyor interviewed CNA #1 who stated that all incontinent residents should be checked every two hours, and every hour if they urinated more frequently because the resident was on diuretics. CNA #1 stated that it was important to assure that residents' incontinent briefs were changed timely, so that they did not develop breakdown of skin. CNA #2 stated that bed linen should also be changed when the resident wets the bed because leaving urine-soaked bed linen on the bed could also cause odor and skin breakdown, and it was not appropriate to put clean bed linen over wet bed linen. CNA #1 stated that when she arrived on the unit, she made rounds with the CNAs from the previous shift so that she could ensure that all the residents were safe, clean, and dry. CNA #1 stated that breakfast was served at 8:00 AM, so residents should be clean and dry before they start their meals. On 6/20/24 at 9:55 AM, the surveyor interviewed the Director of Nursing (DON) who stated that incontinent rounds should be done when staff arrived to the unit to ensure that any priority residents should be taken care of. The DON stated that during shift rounds, the staffs responsibility was to identify soiled residents, change them, and ensure bed linen was changed when soiled; even if a drop of urine got onto the linen, then the linen should be changed. The DON stated that clean linen should not be put on top of dirty linen. The DON stated that all residents should be checked on every two hours to ensure that residents were provided incontinence care timely because residents left soiled were at risk for skin breakdown. On 6/26/24 at 10:36 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON), Assistant Director of Nursing (ADON), and survey team acknowledged it was unacceptable to put chuck on a wet and soiled fitted bed sheet. The DON acknowledged it was not appropriate to make care rounds in the dark. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Bowel and Bladder Incontinence Care policy dated May 2023, included controlling common infections for incontinent residents was part of the overall infection control program .the facility was committed to providing a safe a healthy environment for residents and to minimize or prevent the spread of infections . 45209 2. On 6/19/24 at 10:01 AM, the surveyor observed Resident #73 in their room with their fingernails as long and dirty. When asked if their nails have been cleaned or cut by the facility, Resident #73 denied and voiced that they do not like them long and would like them cut. On 6/20/24 at 9:25 AM, the surveyor observed Resident #73 the facility's lobby biting on their long and dirty fingernails. The surveyor reviewed the medical record for Resident #73. A review of the Order Summary Report revealed that Resident #73 was admitted to the facility with diagnosis that included, but not limited to diabetes mellitus, mood disorder, and hypertension (high blood pressure). A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 5/3/24, reflected a brief interview for mental status (BIMS) score of 12 out of 15, which indicated a moderately impaired cognition. Section GG (Functional Abilities and Goals) of the MDS identified the resident as requiring Substantial/Maximal Assistance with Personal Hygiene. A review of the individualized comprehensive care plan (ICCP) included a focus area dated 10/11/23, for activities of daily living (ADL) Functional/Rehabilitation (Rehab) Potential with interventions that included to have all my needs met. On 6/19/24 at 10:20 AM, the surveyor interviewed CNA #2 and #3 who both confirmed that they were responsible for nail care, which included cleaning and filing the nail to a reasonable length. On 6/20/24 at 11:23 AM, the surveyor interviewed the Registered Nurse who stated that the CNAs were responsible for assisting in residents' ADLs which included nail care. When asked how resident nails are supposed to appear, the RN responded, clean and short with underneath also clean. The RN further explained that skin checks were completed by the CNA daily and weekly by the nurse during bathing, in which nails were checked for length and appearance. On 6/26/24 at 10:35 AM, the LNHA, in the presence of the DON, Regional Nurse, ADON, and survey team acknowledged that it was the expectation of the facility that nail care was completed on the residents. 2. On 6/17/24 at 10:27 AM, the surveyor observed Resident #60 in their room watching television. The surveyor observed Resident #60's nails were long and dirty. When asked if their nails have been cleaned or cut by the facility, Resident #60 denied and stated they would their nails cut. The surveyor reviewed the medical record for Resident #60. (continued on next page)

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	315124	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belle Care Nursing and Rehabilitation Center	439 Bellevue Avenue Trenton, NJ 08618

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnosis that included, but not limited to hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one entire side of the body) following cerebral infarction (stroke) affecting left dominant side, candidiasis (fungal infection) of skin and nail, and bipolar disorder. A review of the most recent quarterly MDS dated [DATE], reflected a BIMS score of 12 out of 15, which indicated a moderately impaired cognition. A review of the ICCP included a focus area dated 7/13/22, for ADL Functional/Rehab Potential with interventions that included personal hygiene expected with limited assistance of one person physical assist. On 6/19/24 at 10:20 AM, the surveyor interviewed CNA #2 and #3 who both confirmed that they were responsible for nail care, which included cleaning and filing the nail to a reasonable length. On 6/20/24 at 11:23 AM, the surveyor interviewed the RN who stated that the CNAs were responsible for assisting in residents' ADLs which included nail care. When asked how residents' nails were supposed to appear, the RN responded, clean and short with underneath also being clean. The RN further explained that skin checks were completed by the CNA daily and weekly by the nurse during bathing, in which nails were checked for length and appearance. At that time, Resident #60 approached the nursing station, and the surveyor questioned the length and appearance of the resident's fingernails. Both the RN and UM/LPN #1 confirmed that they were long, dirty, and unacceptable. On 6/25/24 at 9:43 AM, the surveyor and DON passed Resident #60 in the hallway. At that time, the DON confirmed that their fingernails were long and dirty, and stated that nail care was an everyday thing and it should have been addressed by the CNAs. The surveyor informed the DON that Resident #60's fingernails were previously addressed with the RN and UM/LPN #1 on 6/20/24, and the DON confirmed that the nail care should have been completed at that time. On 6/26/24 at 10:35 AM, the LNHA, in the presence of the DON, ADON, Regional Nurse, and survey team acknowledged that it was the expectation of the facility that nail care was completed on the residents. A review of the facility's Resident Care- Grooming policy dated last reviewed January 2023, included .6. Trim the nails using the nail clipper and file to round the tips of the nails. 7. Clean around and under the nails using a moistened cotton swab. Essential Points: the nursing staff will provide observation and care of nails for all residents on bath day as needed . A review of the facility's undated Certified Nurse Aide Position document included .5. Bathes the resident in bed, tub or shower, combs hair, cleans and cut fingernails and gives shampoos .22. Ensures that residents and families receive the highest quality of service in a caring and compassionate atmosphere which recognizes the individuals' needs and right . A review of the facility's undated Licensed Practical Nurse Position document included .9. Supervises and coordinates nursing personnel in providing direct resident care in adherence with state and federal regulations. 10. Ensures that residents and families receive the highest quality of service in a caring and compassionate atmosphere which recognizes the individuals' needs and right . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated Registered Nurse Position document included .2. 9. Supervises and coordinates nursing personnel in providing direct resident care in adherence with state and federal regulations. A review of the facility's undated Unit Manager/Director Nurse Position document included .4. Assesses the work performance of nursing personnel as it relates to their job description, unit standards of care and goals of the individual 6. Encourages nursing staff to perform their jobs to the fullest of their potential . NJAC 8:39-27.2 (g)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38080 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a Justice Involved Resident (JIR) was provided since admission activities of their choice designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This deficient practice was identified for 1 of 1 JIR (Resident #1) reviewed. The findings were as follows: Reference: The Centers for Medicare and Medicaid Services (CMS) updated Guideline to Surveyors on Federal Requirements for Providing services to Justice Involved individuals, revised 12/23/2016 S & C 16-21-ALL documented Skilled Nursing Facilities must permit residents to have autonomy and choice to the maximum extent practicable regarding how they wish to live their everyday lives and receive care with the same rights as nursing home residents. A review of the facility's Resident Rights dated revised 1/3/24, included 10. all residents will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression .Resident Rights: 1. the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility .5. the resident has the right to be treated with respect and dignity including: the right to be free from physical or chemical restraints imposed for the purpose of discipline or convenience [.] the right to retain and use personal possessions [.] the right to receive services in the facility with reasonable accommodation of resident needs and preferences [.]the right to share a room with a roommate of his/her choice [.] 6. Self-determination: the resident has the right to and the facility must 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 with members of the community; receive visitors of their choosing at the time of their choosing .participate in other activities including social, religious, and community activities .8. Privacy and confidentiality: the resident has the right to personal privacy and confidentiality of their personal and medical records .9. Safe environment: the resident has the right to a safe, clean, comfortable and homelike environment . A review of the facility's Activities policy dated reviewed 5/1/24, included the facility's activity programs are designed to meet the needs of each resident and are available on a daily basis .the facility's activity programs are designed to encourage participation and are individualized to meet each resident's needs . (continued on next page)

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F 0679

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 8/29/24 at 9:45 AM, the surveyor observed a personal protective equipment (PPE) bin outside of Resident #1's room. At that time, the surveyor interviewed the Licensed Practical Nurse Supervisor (LPN Supervisor #1), who stated Resident #1 had a stage 4 pressure wound (full-thickness skin loss extends through the fascia with considerable tissue loss) to their right buttock, and when staff provided care, they needed to don (wear) additional PPE. The surveyor asked if staff had to wear PPE when the resident was out of the room, and LPN Supervisor #1 stated that Resident #1 was a Justice Involved Resident (JIR) who remained in their room unless to go to the rehabilitation (rehab) gym. LPN Supervisor #1 continued that the resident did not participate in activities; ate all their meals in their room on disposable ware; wore an orange jumpsuit in therapy; visitors needed to be scheduled through the CF by appointment; and the resident always remained in the room alone with two armed Correctional Officers (COs).

On 8/29/24 at 9:55 AM, the surveyor observed Resident #1 lying in bed with two-armed COs (CO #1 and CO #2) who were on their cell phones stationed at the resident's door (CO #1) and the resident's window (CO #2). At that time, the surveyor interviewed the resident, who stated they had been at the facility for over a year now, and they were receiving rehab and wound care at the facility. Resident #1 stated that they wanted to return to the Correctional Facility (CF); they were lonely and depressed at the facility because they remained in their room twenty-four hours a day, seven days a week with two COs and a television. The resident stated they ate in their room on disposable ware and there were no activities. Resident #1 stated that they were prohibited visitors unless the CF approved the visits, and the CF was not responding to their visitors for appointments. Resident #1 stated they were waiting for grievance paperwork from the CF to complain about it, which they had not received, and the CF's Social Worker (SW) was supposed to come to the facility weekly so they could have their weekly phone call. Resident #1 stated the CF's SW maybe came to the facility twice a month, so they missed their allowed phone calls, and the resident wanted to call their attorney to request to be transferred back to the CF. Resident #1 stated they had no privacy, anytime they received care the COs were in the room, and if they had visitors or made a call, the COs were present. Resident #1 stated that when they went to rehab, they wore an orange jumpsuit which embarrassed them because it let everyone know they were a JIR. The surveyor asked if the resident had to wear any cuffs (wrist or ankle) in the room or in rehab, and the resident stated, no, they could not walk. The surveyor asked if the resident saw the facility's SW, and the resident stated, no, but they thought they were supposed to.

At the time of the interview, the surveyor asked CO #1 if everything the resident reported was accurate, and the CO confirmed yes, the resident was incarcerated.

On 8/29/24 at 10:41 AM, the surveyor reviewed the medical record for Resident #1.

A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; paraplegia (leg paralysis); chronic pain; depressive disorder; anxiety disorder; insomnia; and stage 4 pressure ulcer of right buttock.

A review of the Progress Notes included a Nursing Note dated 4/27/23 at 7:37 AM, which included the resident was admitted to the facility on [DATE] at 6:55 PM, accompanied by two COs. The resident was admitted with a right ischial (lower buttock) pressure sore; was receiving intravenous (IV) antibiotics; and had a wound vacuum (negative pressure wound therapy treatment that uses suction to assist in wound healing).

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NAME OF PROVIDER OR SUPPLIER: Belle Care Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 439 Bellevue Avenue Trenton, NJ 08618	

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F 0679

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 7/31/24, reflected the resident had a brief interview for mental status score of 15 out of 15, which indicated a fully intact cognition.

A review of the individual comprehensive care plan (ICCP) included the following focus areas:

A focus area dated 7/3/24, that the resident was not permitted access to telephones, not landlines or cell phones. In the rare circumstances when phone use was permitted, the CF, not the staff take care of it. The resident was not permitted to go out on pass or out of the facility unless escorted by COs and authorized by the CF. The intervention was that the resident would be closely monitored by the CF.

A focus area dated 7/3/24, inmate 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 would maintain stable weight and be free from dehydration.

The ICCP did not include a focus area for activities.

On 8/29/24 at 11:24 AM, the surveyor interviewed the facility's SW, who stated she had just started at the facility last week and had not gotten to speak to all the residents yet. The surveyor asked if the SW spoke with Resident #1, and she stated no, but the resident was on her list.

On 8/29/24 at 11:55 AM, the surveyor interviewed the Director of Activities (DA) who stated activities were conducted in groups on both nursing units, and staff did one-to-one (1:1) activities as needed. The DA stated that 1:1 activities included providing puzzles and crossword puzzles. The surveyor asked if she provided 1:1 activities for Resident #1, and the DA stated that activity staff did not see them that often. The DA continued that there were two COs in there and staff were not really supposed to be in there; that she could not provide any activities, crossword puzzles, or games. The DA stated the resident requested a pack of playing cards about a month ago, and the facility was not allowed to provide, that the CF's SW had to provide.

On 8/29/24 at 12:30 PM, the surveyor observed Resident #1 sitting in a wheelchair being transported down the hallway in wrist and ankle cuffs in an orange jumpsuit with three-armed COs. The surveyor asked Resident #1 where they were going, and the resident stated to see the wound doctor, that they did not want to see the doctor here. The resident reported their appointment was at the hospital, and that their wound was improving. The surveyor asked the resident if they ever received the playing card they requested, and the resident confirmed no.

On 8/29/24 at 12:56 PM, the surveyor interviewed the LNHA in the presence of the DON, who stated that she had started at the facility on 4/11/24, and the previous owners of the facility had a contract with the CF since 2022. The LNHA stated that the JIRs were only at the facility for medical services, and when their medical treatment was completed, the JIRs returned to the CF. The LNHA continued that Resident #1 stayed in their room with the two COs and went to rehab accompanied by them. The LNHA stated that everything was controlled by the CF; that the facility could not provide playing cards; phone usage; visitors. The LNHA stated the CF's SW 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.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, the DON stated that the resident informed the facility that the CF had to approve all visits, and the resident could not have a visitor unless the CF approved it. The DON stated there were no private visits, that there were always COs; the resident could not be without them. The DON stated it was the CF's policies; the resident could have no other clothes except their orange jumpsuit that identified them as a JIR as a safety precaution. The DON stated only the resident and the COs could be in the elevator during transportation, and the resident saw an outside wound doctor that the appointments were scheduled by the CF. The DON stated that Resident #1 received the same level of care as all the other residents in the facility, they just did not have the freedoms. The DON stated that the facility was in control of the resident's nursing care, and everything else was controlled by the CF. The surveyor requested a copy of the resident's activity assessments. On 8/29/24 at 3:05 PM, the DON informed the survey team that she had spoken to the CF to have the CF inform the facility who was permitted to visit the resident and when. No additional information was provided. NJAC 8:39-7.3(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 44833 Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to a.) obtain a physician's order for pressure reducing devices and b.) implement the individualized comprehensive care plan (ICCP) intervention to use a pressure reducing device on a resident's bed. This deficient practice was identified for 1 of 1 resident reviewed for pressure ulcer/injury(Resident #9), and was evidenced by the following: On 6/17/24 at 10:54 AM, during initial tour of the facility, the surveyor observed Resident #9 lying in bed. The resident was on a regular mattress which was placed atop a deflated low air loss mattress/pressure reducing mattress, which was connected to an air pump that was not plugged into the power outlet or turned on. On 6/19/24 at 11:01 AM, the surveyor observed Resident #9's bed which contained a regular mattress covered with bed linens placed on top of a a deflated low air loss mattress. The resident was not present at the time of observation. On 6/19/24 at 11:05 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN) who stated, Resident #9 was being followed by wound care consultations (consults) for a pressure ulcer, which was now resolved. The UM/LPN reviewed the resident's ICCP with the surveyor, and identified that the resident was care planned for being at risk for skin breakdown, having been treated for a pressure ulcer with interventions that included to use a pressure reducing device when in bed. The UM/LPN further stated that the resident did not have physician's order for pressure reducing devices. At that time, the surveyor and the UM/LPN went to the resident's room to observe the mattress setup. The UM/LPN confirmed that there was a regular mattress on top of deflated air loss/pressure reducing mattress. The UM/LPN acknowledged there was no pressure reducing device in bed for the resident; that the air mattress underneath the regular mattress was used incorrectly. The surveyor reviewed the medical record for Resident #9. A review of the Admission Record face sheet (an admission summary) indicated the resident was admitted to the facility with diagnosis which included rash and other nonspecific skin eruption and erythematous condition (skin redness can have causes that are not due to underlying disease. Examples include too much pressure on the area, blushing, or exercise). A review of the current Physician Order Summary Report did not include a physician's order for use of pressure reducing devices. A review of the ICCP included a focus for risk for skin breakdown with interventions which included the use of pressure reducing device for bed and chair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 4/9/24, indicated under section M: Skin Conditions that the resident had one stage two pressure ulcer (partial thickness loss of dermis skin layer presenting as a shallow open ulcer with a red or pink wound bed) with treatments including pressure reducing device for chair and for bed. On 6/20/24 at 10:34 AM, in the presence of the survey team, the surveyor interviewed the Director of Nursing (DON) confirmed that Resident #9 had history of pressure ulcers and that the resident should be on a pressure reducing air mattress set to the resident's weight. The DON was presented with a photograph of how the resident's bed was arranged with a regular mattress atop a deflated air mattress, to which the DON stated that was unacceptable and that she had never seen that done this way, we don't use it this way. She further stated we should not have a regular mattress on top, it defeats the purpose [of the air mattress]. On 6/26/24 at 10:46 AM, the surveyor, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA), and Assistant Director of Nursing (ADON), asked the DON if Resident #9 had an order for use of a pressure reducing device on the bed, to which the LNHA shook her head No and the DON stated, there should have been one. Review of the facility's Wound Prevention and Treatment policy dated reviewed March 2024, included Pressure Ulcer Prevention .Provide a pressure reduction surface for bed and/ or wheelchair per the facility's Support Surface Selection Algorithm. (Refer to Algorithm of this Wound Prevention and Management Protocol) .Stage II Treatment .Notify physician and obtain orders for the most appropriate treatment protocol . NJAC 8:39-27.1(e)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 49094 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to monitor an enteral tube feeding administration pump to ensure the total volume administered was in accordance with physician's orders. This deficient practice was identified for 1 of 1 residents reviewed for tube feeding (Resident #32), and was evidenced by the following: On 6/17/24 at 10:54 AM, the surveyor observed Resident #32 lying in bed awake with a tube feeding pump (TF; a tube feeding surgically inserted into the stomach) was located on a pole near their bed. There was no nutritional formula being administered at this time. When asked by the surveyor if they received tube feedings daily, Resident #32 shook their head indicating yes. On 6/19/24 at 10:35 AM, the surveyor observed Resident #32 lying in bed awake with the TF pump administering Jevity 1.5 (nutritional formula) at a rate of 70 milliliters (mL) an hour with a total volume infused thus far of 464 mL. The Jevity 1.5 bottle was labeled as hung on 6/18/24 at 7:30 PM. On 6/19/24 at 12:30 PM, the surveyor observed Resident #32 lying in bed with the TF pump administering Jevity 1.5 at a rate of 70 mL an hour with a total volume infused thus far of 600 mL. The surveyor reviewed the medical record for Resident #32. According to the Admission Record face sheet (admission summary), the resident was admitted to facility with diagnoses which included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), gastro-esophageal reflux disease (stomach acid repeatedly flows back up into the tube connecting the mouth and stomach), dysphagia (difficulty swallowing), aphasia (affects how you communicate), and vitamin deficiency (do not have enough vitamins in the body). According to the most recent Minimum Data Set (MDS), an assessment tool dated 3/22/24, revealed Resident #32 did not have a Brief Interview for Mental Status (BIMS) score due to the resident was rarely or never being understood with short term and long-term memory problems with moderately impaired cognition. A review of the MDS Section K. Swallowing/Nutritional Status, revealed that Resident #32 had a feeding tube (TF) while a resident, and received more than 51% of their total calories through the tube feeding. A review of the individualized comprehensive care plan (ICCP) dated effective 7/13/22 to present, included that the resident required a TF for nutritional support related to need for nothing by mouth (NPO) status with dysphagia. Interventions included to monitor labs as ordered; tolerate tube feeding; maintain fairly stable weight without significant change; provide Jevity 1.5 as ordered; and monitor weight monthly. A review of the June 2024 Physician Order Sheet (POS) included a physician's order (PO) dated 6/10/24, to administer Jevity 1.5 via pump at the rate of 70 mL an hour; start at 4:00 PM (4 PM) until completion of total volume to equal 1260 mL. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the corresponding June 2024 electronic Medication Administration Record (eMAR) indicated the following: The TF order for Jevity 1.5 was signed by the nurse indicating it was administered at 4 PM on 6/18/24. A review of the corresponding June 2024 Administration History Report indicated that on 6/18/24, the enteral tube feeding Jevity 1.5 was hung at 4:50 PM. During an interview with the surveyor on 6/19/24 at 12:15 PM, the Unit Manager/Licensed Practical Nurse (UM/LPN) was asked how the facility monitored the amount of formula infused by the TF pump. The UM/LPN responded, if the resident's tube feeding order was for a total volume amount of 1270 mL, then the pump was set to administer the total volume of 1270 mL, and the pump stopped when the total volume was infused. The UM/LPN also stated that the nurse signed on the eMAR when they started the tube feeding, but the nurses did not document the total volume infused at the end of each shift. On 6/19/24 at 12:30 PM, the UM/LPN accompanied the surveyor to Resident #32's room, and they observed the resident in bed with the TF running at a rate of 70 mL per hour with a total volume of 600 mL infused. The UM/LPN stated that Resident #32's TF was usually completed around 10:00 AM, and that possibly the nurse who changed the Jevity 1.5 bottle, cleared the total volume infused on the pump which the UM/LPN confirmed they should not do. The surveyor asked can you determine the total amount of the Jevity 1.5 that the resident received since the feeding was started on 6/18/24 at 4 PM, and the UM/LPN responded, they could not say for certain if the total volume was cleared. The UM/LPN also acknowledged that the TF would continue to administer the formula until it reached a total volume of 1270 mL which would take approximately nine hours to reach that volume, and it would overlap the resident's next feeding that started at 4 PM. The UM/LPN also acknowledged it was possible that the resident could have received more than 1270 mL, since the feeding usually ended at 10:00 AM, and overfeeding could have led to the resident vomiting. At that time, the UM/LPN instructed a nearby nurse to stop the feeding. On 6/20/24 at 12:30 PM, the surveyor interviewed the Director of Nursing (DON) who stated that a resident's TF was hung according to the physician's orders; that the TF should be administered at the time ordered, and continue to infuse until the resident received the total volume. When asked how do the facility monitored the total volume administered each shift, the DON responded, the total volume the resident received was displayed on the pump. The DON also stated the nurse documented on the eMAR when the TF was started, but the nurses did not document the total volume administered each shift. The surveyor then asked, how do you know if Resident #32 received the ordered amount of Jevity 1.5 6/19/24, if at 12:30 PM, the TF pump indicated 600 mL as the total volume. The DON stated that she could not confirm if the resident received the ordered amount, and the nurse should have documented in the Progress Notes if they held the feeding and why, and it should have been communicated to the next shift. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Belle Care Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 439 Bellevue Avenue Trenton, NJ 08618	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 10:35 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), Assistant Director of Nursing (ADON), and survey team stated that through interviews with staff, they were assuming the tube feeding was hung late, and the nurse should be have been checking and making rounds on the units. The DON acknowledged the facility needed to be more diligent in tracking when the tube feeding was hung and how much was infused each shift, and the nurse should have documented if the TF was hung late or the feeding was held for a length of time. When asked if the facility conducted an investigation, the DON stated that she verbally spoke to staff but did not document anything. The DON also acknowledged there was no documentation that the physician was made aware. The DON could not speak to why the nurse signed the TF was started on 4/18/24 at 4:50 PM, but acknowledged it was not appropriate to start the next TF directly after the previous TF ended. A review of the facility's Enteral Feeding policy dated revised 5/1/11, included Procedure: [.] 16. Document administration of feeding on Medication Administration Record (MAR) including: Date, Formula, Rate and Continuous bolus. 17. Document total intake separated into formula and water flush on MAR or Intake & Output Record if applicable. 18. Document the following, including, but not limited to: Tube placement verification, Time tube feeding initiated, Resident/patient tolerance, and Amount of gastric residual, as applicable . NJAC 8:39-27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to provide sufficient nursing staff to ensure residents were provided with care to achieve their highest practical wellbeing by failing to ensure a.) incontinence care was provided for 2 out of 7 residents observed during incontinence rounds (Resident #32 and Resident #147) and b.) medications were administered according to physician's orders for 4 of 4 residents reviewed for medication administration timing (Resident #32, #43, #60, and #250). This deficient practice was evidenced by the following: Refer F658 and F677 1. According to the Admission Record (AR), Resident #147 was admitted to the facility with the diagnoses which included but not limited to chronic respiratory failure and tracheostomy (hole in the windpipe to facilitate breathing). The most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 4/10/24, reflected that Resident #147 had moderate cognitive deficits and was dependent on staff for hygiene. Resident #147's individualized comprehensive care plan (ICCP) reflected that the resident required total dependence and one-person physical assistance with personal hygiene. According to the AR, Resident #32 was admitted to the facility with the diagnoses which included but not limited to cerebral infarction (stroke). The most recent comprehensive MDS dated [DATE], reflected that Resident #32 had severe cognitive deficits and was dependent on staff for hygiene. Resident #32's ICCP reflected that the staff provided incontinent care every two to four hours and that the resident required total dependence and one-person physical assistance with personal hygiene. On 6/18/24 at 8:02 AM, the surveyor conducted an incontinence tour on the Second Floor nursing unit accompanied by the Unit Manager/Licensed Practical Nurse (Um/LPN #1) and observed the following: The surveyor and UM/LPN #1 entered Resident #147's room who was observed lying in bed. UM/LPN #1 asked the resident if she could check their incontinent brief and the resident gave UM/LPN #1 permission. The surveyor observed that the resident's incontinent brief was dry and the chuck (protective bed pad) that was directly under the resident was dry, however the fitted sheet located under the chuck had a large brown/yellow stain that smelled like urine and contained some dry brown stains which UM/LPN #1 identified as bowel movement (bm). UM/LPN #1 was interviewed at that time, and stated that the Certified Nursing Aide (CNA) that was assigned to care for Resident #32 should have changed the resident's sheet when performing incontinence care and should not have left a urine-soaked sheet on the resident's bed. UM/LPN #1 stated that the Agency CNA that cared for the resident on 11:00 PM to 7:00 AM shift must have left the dirty sheet on the resident's bed because the CNA (CNA #1) that came in that morning just got to the unit and had not made rounds yet. UM/LPN #1 stated that incontinence rounds were completed by the CNA every two hours. The surveyor observed the resident's skin during the tour and the resident's skin was free of skin breakdown. A review of the CNA Assignment sheet for 6/18/24, revealed that for the resident census of 47, there were five assigned CNAs. CNA #1 had thirteen assigned residents to care for. (continued on next page)

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	315124	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belle Care Nursing and Rehabilitation Center	439 Bellevue Avenue Trenton, NJ 08618

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/18/24 at 8:45 AM, the surveyor conducted an incontinence tour on the First Floor nursing unit with a Licensed Practical Nurse (LPN) and observed the following: On 6/18/24 at 9:00 AM, the surveyor accompanied the LPN into Resident #32's room observed the resident lying in bed and was non-verbal. The resident's incontinence brief was observed to be very wet with urine and the sheets were observed with a large urine stain that had a strong smell of urine. The LPN was interviewed at the time and confirmed that the stain the surveyor observed on the resident's sheet was urine and that the resident's incontinence brief should have been changed and the entire bed linen should have been changed. The resident's skin was observed, and the resident's skin was intact and free of breakdown. On 6/18/24 at 9:10 AM, the surveyor interviewed UM/LPN #2 for the First Floor nursing unit who stated that CNA #2 who was assigned to care for Resident #32 should have made rounds that morning when she had arrived at the unit and checked the residents to see if any residents were incontinent and needed to be changed right away. UM/LPN #2 could not speak to why Resident #32 was wet including the resident's bed linens. UM/LPN #2 stated it was import to assure that the residents were clean and dry to protect the resident's skin and to keep residents comfortable. A review of the CNA Assignment sheet for 6/18/24, revealed that for the resident census of 50, there were five assigned CNAs. CNA #2 had eleven assigned residents to care for. On 6/18/24 at 9:20 AM, the surveyor interviewed the CNA #2 who stated that she made rounds that morning and performed an incontinence check for Resident #32. CNA #2 stated that she did not see the large urine stain on the resident's bed sheets and did not notice that the resident's incontinence brief was soaked with urine because she did not turn the light on in the resident's room. CNA #2 stated that the resident's incontinence brief and bed linen should have been changed and that it must have been an oversight. On 6/19/24 at 9:08 AM, the surveyor interviewed CNA #1 who stated that all incontinent residents should be checked every two hours, and if a resident urinated more frequently because the resident was on diuretics, that they should be checked every hour. CNA #1 stated that it was important to assure that residents' incontinent briefs were changed timely so that they did not develop breakdown of skin, as well as bed linen should be changed when the resident wets the bed. CNA #1 explained that leaving urine-soaked bed linen on the bed could also cause odor and skin breakdown, and it would not be appropriate to put clean bed linen over wet bed linen. CNA #1 stated that when she arrived on the unit, she made rounds with the CNAs from the previous shift so that she could ensure that all the residents were safe, clean, and dry. CNA #1 stated that breakfast was served at 8:00 AM, so residents should have been clean and dry before they started their meals. On 6/20/24 at 9:55 AM, the surveyor interviewed the Director of Nursing (DON) who stated that incontinence rounds should be done when staff arrived at the unit to ensure that any priority residents should be taken care of. The DON stated that during shift rounds, the staffs responsibility was to identify soiled residents and to ensure that the residents were changed and bed linen were changed when soiled, emphasizing that even if a drop of urine got onto the linen, then the linen should be changed. The DON stated that clean linen should not be put on top of dirty linen, and all residents should be checked on every two hours. The DON explained that it was important to assure that residents were provided incontinence care timely and that residents left soiled were at risk for skin breakdown. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/24 at 10:13 AM, the surveyor interviewed the Staffing Coordinator in the presence of the Licensed Nursing Home Administrator (LNHA), who stated she scheduled nursing staff in accordance with State regulation which required one CNA to every eight residents for the morning shift; one CNA for every ten residents for the evening shift; and one CNA to every fourteen residents for the overnight shift. The Staffing Coordinator stated it was very hard to find staff; that the facility did not always meet the required ratios. On 6/26/24 at 10:36 AM, the LNHA in the presence of the DON, Assistant Director of Nursing (ADON), and survey team acknowledged it was unacceptable to put chuck on a wet and soiled fitted bed sheet. The DON acknowledged it was not appropriate to make care rounds in the dark. 38080 2. During entrance conference on 6/17/24 at 10:00 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) how the facility's staff was, and the LNHA stated that the facility relied heavily on Agency staffing. At that time, the surveyor requested the Nurse Staffing Report to be completed for the weeks of 11/6/22 to 11/19/22. On 6/18/24 at 11:56 AM, the LNHA informed the surveyor that the facility did not have the staffing records for 2022; that they were trying to get the information from the payroll company. The surveyor asked the LNHA if the facility needed to maintain staffing records, and the LNHA confirmed the facility should have the records. On 6/25/24 at 10:13 AM, the surveyor reviewed the Nurse Staffing Report sheets completed by the facility for 11/6/22 through 11/19/22 which revealed the following: On 11/6/22, there was a census of 91 residents with a total of four nurses throughout the twenty-four hour period. On 11/7/22, there was a census of 91 residents with a total of two nurses throughout the twenty-four hour period with no nurses on the overnight. On 11/8/22, there was a census of 91 residents with a total of four nurses throughout the twenty-four hour period. On 11/9/22, there was a census of 93 residents with a total of three nurses throughout the twenty-four hour period with no nurses on the overnight. On 11/10/22, there was a census of 93 residents with a total of four residents throughout the twenty-four hour period. On 11/11/22, there was a census of 92 residents with a total of four nurses throughout the twenty-four hour period. On 11/12/22, there was a census of 93 residents with a total of three nurses throughout the twenty-four hour period. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/13/22, there was a census of 93 residents with a total of two nurses throughout the twenty-four hour period with no nurses on the evening shift. On 11/14/22, there was a census of 94 residents with a total of two nurses throughout the twenty-four hour period with no nurses on the overnight shift. On 11/15/22, there was a census of 95 residents with a total of three nurses throughout the twenty-four hour period. On 11/16/22, there was a census of 95 residents with a total of three nurses throughout the twenty-four hour period with no nurses on the evening shift. On 11/17/22, there was a census of 93 residents with a total of two nurse throughout the twenty-four hour period with no nurse on the evening shift. On 11/18/22, there was a census of 94 residents with a total of one nurse throughout the twenty-four hour period with no nurses on the day or evening shifts. On 11/19/22, there was a census of 93 residents with a total of one nurse throughout the twenty-four hour period with no nurse on the day or evening shifts. At that time, the LNHA stated that the facility could not locate the November 2022 staffing sheets, and they used payroll documents to complete the staffing report. The LNHA stated the facility relied heavily on Agency staff who were not included in those reports. On 6/25/24 at 10:17 AM, the surveyor interviewed the Staffing Coordinator in the presence of the LNHA who stated she was not here at the time, and could not locate the staffing sheets for that time. The Staffing Coordinator stated she could reach out to the Agencies to determine the staff provided. On 6/25/24 at 10:21 AM, the surveyor interviewed the DON in the presence of the LNHA and Staffing Coordinator who acknowledged the staffing sheets needed to be maintained and kept as a reference at all times. The DON stated the unit managers kept records of the assignment sheets, but the sheets cannot be located. The DON acknowledged her role was to oversee the nursing department, and confirmed the staffing levels were not acceptable. At that time, 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 11/6/22 through 11/19/22. On 6/25/24 at 12:30 PM, the LNHA provided the surveyor with Administration Documentation Audit Detail Report (ADADR) for the weeks of 11/1/22 to 11/13/22 for Resident #32, #43, and #250. The LNHA stated Resident #252 was discharged from the facility in July of 2022, and Resident #43 was out of the facility at the time so she provided the week of 11/25/24. On 6/25/24 at 1:30 PM, the surveyor interviewed the DON who stated medication should be administered as ordered; the right person, medication, dose, route, and time. The DON continued medication was to be administered at the time prescribed or one hour before or after the medication was timed for. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed the ADADR reports provided which revealed the following: For the weeks of 11/1/22 through 11/13/22: For Resident #32, their medications were administered out of the time parameters: for the 8:00 AM dose on 11/2/22, 11/3/22, 11/4/22, 11/5/22, 11/6/22, 11/7/22, 11/10/22, 11/11/22, 11/12/22, and 11/13/22; for the 9:00 AM doses on 11/4/22, 11/5/22, 11/11/22, and 11/12/22; for the 12:00 PM doses on 11/2/22, 11/3/22, 11/4/22, 11/8/22, 11/10/22, and 11/11/22; for the 5:00 PM doses on 11/2/22, 11/3/22, 11/4/22, and 11/11/22; for the 6:00 PM dose on 11/2/22; and the 10 PM dose on 11/11/22. It was documented the residents tube feeding (nutrition administered through a surgical tube into the stomach) scheduled at 4:00 PM, was administered late on 11/3/22, 11/7/22, 11/8/22, 11/9/22, 11/11/22, and 11/12/22. It was also documented on 11/4/22, that their 8:00 AM medications were administered at 2:04 PM; and their 11/11/22 8:00 AM and 9:00 AM medications were administered at 1:26 PM. For Resident #60, their medications were administered out of the time parameters: for the 8:00 AM doses on 11/1/22; 11/2/22; 11/3/22; 11/4/22; 11/5/22; 11/6/22; 11/7/22, 11/9/22, 11/11/22, 11/12/22, and 11/13/22; for the 9:00 AM doses on 11/1/22, 11/4/22, 11/5/22, and 11/12/22 for the 1:00 PM doses on 11/1/22, 11/2/22, 11/3/22, 11/4/22, 11/7/22, 11/8/22, and 11/11/22; for the 5:00 PM doses on 11/2/22, 11/3/22, 11/4/22, 11/7/22, 11/11/22, and 11/12/22; and the 9:00 PM doses on 11/2/22, 11/11/22, 11/12/22, and 11/13/22. It was documented that they received their 11/4/22 9:00 AM medications at 2:18 PM. For Resident #250, their medications were administered out of the time parameters: for the 8:00 AM dose on 11/11/22; for the 9:00 AM doses on 11/3/22, 11/8/22, 11/9/22, 11/11/22, 11/12/22, and 11/13/22; for the 1:00 PM doses on 11/9/22, 11/10/22, and 11/13/22; and the 5:00 PM doses on 11/3/22, 11/4/22, 11/5/22, and 11/8/22. It was documented the resident's 9:00 AM doses on 11/3/22 were administered at 1:52 PM, and their 5:00 PM doses on 11/5/22 were administered at 10:26 PM. For the week of 11/25/22 through 11/30/22, Resident #43's medications were administered out of the time parameters: for the 9:00 AM dose on 11/29/22; the 5:00 PM dose on 11/27/22; and the 6:00 PM dose on 11/27/22. It was documented the 9:00 AM medications were administered at 12:06 PM on 11/29/22. On 6/26/24 at 10:30 AM, the LNHA provided additional staffing for the weeks of 11/6/22 through 11/19/22, which revealed on 11/6/22, there were three nurses for the day shift and one for the overnight; on 11/7/22, there were two nurses for the day and overnight shifts and three for the evening; on 11/8/22 there were three nurses for the evening and two nurses for the overnight shifts; on 11/9/22 four nurses for the day shift, two for the evening and one for the overnight shifts; on 11/10/22 there was four for the day, three for the evening, and two for the overnight shift; for 11/11/22 there was four for the day, three for the evening, and one for the overnight shift; on 11/12/22 there were two nurses for the day four for the evening, and two for the overnight; for 11/13/22 there was three for the day, two for the evening, and one for the overnight; for 11/14/22 there was two for the evening and one for the overnight; for 11/15/22 and 11/16/22 there was two for the evening and overnight; 11/17/22 there were three for the evening and two for the overnight; for 11/18/22 there were three for the evening and one for the overnight; and for 11/19/22 there were two for the evening and one for the overnight. On 6/26/24 at 10:34 AM, the LNHA acknowledged these concerns. (continued on next page)

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Belle Care Nursing and Rehabilitation Center	439 Bellevue Avenue Trenton, NJ 08618

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Bowel and Bladder Incontinence Care policy dated May 2023, included that controlling common infections for incontinent residents was part of the overall infection control program .the facility was committed to providing a safe a healthy environment for residents and to minimize or prevent the spread of infections . A review of the facility's Nursing and Sufficient Staff policy dated last reviewed July 2023, included it is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment .the facility will supply sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans . NJAC 8:39-25.2 (a); 27.1(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34033 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards by not ensuring a.) the accurate documentation of medication administration during the 6/18/24 medication administration observation for ten residents by 1 of 2 nurses; b.) accurate documentation of the administration of a medication (Depakote) according to physician's orders from 6/11/24 until surveyor inquiry; c.) accurate inventory documentation of a controlled medication (methadone) administered on 6/17/24; d.) maintain accurate documentation for signing the controlled drug shift-to-shift inventory counts of the controlled medications on the morning shift of 6/18/24 by 1 of 2 nurses observed during the medication administration observation and an additional six shifts in June for one 1 of 2 medication carts inspected; and e.) accountability of the narcotic shift count logs were completed in accordance with facility policy and accurately account for and document the administration of controlled medications identified on 2 of 2 medication carts and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The deficient 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 agency nurse, and she had a problem with her login. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/18/24 at 8:21 AM, the surveyor observed RN #1 entering electronic signatures for the 8:00 AM (8 AM) and 9:00 AM (9 AM) medications for four sampled residents, (Resident #32, #61, #79, and #84), and six unsampled residents, (unsampled Resident #1, #2, #3, #4, #5, #6). RN #1 stated that she had already administered the morning medications to those residents and needed to sign the eMAR. RN #1 explained that she administered morning medications to the residents earlier because they were a priority since the residents were either diabetic, on dialysis or had a feeding tube (surgical tube inserted into the stomach), and she had not had a chance to sign the eMAR. On 6/18/24 at 8:45 AM, the surveyor observed RN #1 administer and electronically sign for medications that were administered to Resident #51. A review of the eMARs for Resident #89, #51, #32, #61, #79, #84 and the six unsampled residents revealed that the initials for the 8 AM and 9 AM medications on 6/18/24 had the electronic signature initials for UM/LPN #1. On 6/18/24 at 11:27 AM, the surveyor interviewed UM/LPN #1 at the nurse's station, who stated that she had given RN #1 her login because there was a problem this morning. In addition, UM/LPN #1 stated that medications should be signed for immediately after administering them to the resident. At that time, the Assistant Director of Nursing (ADON) was at the nurse's station and confirmed UM/LPN #1 should not have given RN #1 her login password. The ADON stated that when the computer system changed on 6/11/24, the staff were trained on how to use the system, but that agency nurses were already familiar with the system. On 6/18/24 at 12:12 PM, the surveyor interviewed the Human Resources/Staff Coordinator (HR/SC) who stated that she was responsible for providing the login passwords for the agency nurses. The HR/SC also stated that each nurse had their own login password, and that she had tested RN #1's login password at 7:45 AM that morning, but that RN #1 had entered the password wrong three times and was locked out. On 6/19/24 at 8:30 AM, the surveyor interviewed the Director of Nursing (DON) who stated that every nurse had their own login password and were not to use another nurse's login. The DON added that UM/LPN #1 should not have given her login password to RN #1 because the login corresponded to the nurse's signature. The DON explained that the administrative staff which included the UM had the capability to unlock the RN's login or provide a new one. The DON also stated that the computer system was changed on 6/11/24, but that nursing procedures were still to be followed. The DON explained that the eMAR was to be signed immediately after the medication was administered. On 6/19/24 at 3:50 PM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone who stated that she had started as the CP in March of 2024, and she had not done any medication passes on nurses or inservices for medication administration yet. On 6/20/24 at 1:21 PM, the survey team met with the DON and the Licensed Nursing Home Administrator (LNHA). The DON stated that there were no medication administration observations performed with RN #1, and the facility had not done any inservices on medication administration recently. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belle Care Nursing and Rehabilitation Center	439 Bellevue Avenue Trenton, NJ 08618

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Medication Administration Policy dated 12/23/2, included that after medication administration document necessary medication administration/treatment information (e.g. (for example), when medications are administered, medication injection site, refused medications, and reason, prn (as needed) medications, etc.) on appropriate forms . 2. On 6/18/24 at 8:59 AM, during the morning medication administration pass, the surveyor, observed RN #2 preparing eight medications for Resident #5 which included a 125 milligram (MG) tablet of divalproex sodium delayed release (Depakote) (a medication used for mood stabilization). On 6/18/24 at 9:08 AM, the surveyor observed RN #2 administer seven medications to Resident #5 which included the Depakote 125 MG tablet. Upon returning to the medication cart, the surveyor observed RN #2 electronically sign the eMAR for Resident #5 for all the highlighted medications that were due for 9 AM. The surveyor reviewed the medical record for Resident #5. A review of the Admission Record face sheet (admission summary) revealed diagnoses that included bipolar disorder (a mental health disorder) and generalized anxiety disorder. A review of the Order Summary Report revealed a physician's order (PO) with a start date of 6/6/24, for Depakote 125 MG tablet, give 1 tablet orally two times a day for bipolar disorder. Give with 500 MG for a total dose of 625 MG. Further review of the Order Summary Report revealed PO with an active date of 4/29/24, and a start date of 6/30/24, for Depakote 500 MG tablet; give 1 tablet orally two times a day for bipolar disorder. Give with 125 MG for a total dose of 625 MG. A review of the June eMAR revealed the above PO for Depakote 125 MG. In addition, the eMAR revealed a PO dated 6/30/24, for Depakote 500 MG tablet; give 1 tablet orally two times a day for bipolar disorder. Give with 125 MG for a total dose of 625 MG. The eMAR reflected all June dates with an X until 6/30/24. There was no documentation that Depakote 500 MG was administered from 6/11/24 until surveyor inquiry. On 6/18/24 at 12:23 PM, the surveyor interviewed UM/LPN #2 regarding the dose of Depakote that was to be administered at 9:00 AM (9 AM) to Resident #5. UM/LPN #2 checked the electronic records for Resident #5 and stated that the facility had changed electronic charting systems recently and was checking both systems. UM/LPN #2 then verified that the dose of Depakote that Resident #5 was to receive at 9 AM was a total of 625 MG. UM/LPN #2 explained that there was a PO for Depakote 125 MG and Depakote 500 MG to be administered together for a total dose of 625 MG. UM/LPN #2 then reviewed the current eMAR and stated that the Depakote 500 MG order was entered incorrectly because the PO had a start date of 6/30/24, and should have been started on 6/11/24, with the Depakote 125 MG PO. UM/LPN #2 added that the Depakote 125 MG PO had instructions regarding the total dose, but that when the electronic system started on 6/11/24, the Depakote 500 MG dose would not be highlighted for administration at 9 AM until 6/30/24. UM/LPN #2 was unable to speak to how the PO was entered incorrectly. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Belle Care Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 439 Bellevue Avenue Trenton, NJ 08618	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the previous computer system Physician's Orders revealed a PO dated 9/13/22, for Depakote 125 MG tablet, delayed release; give 1 tablet (125 MG) by oral route 2 times per day. Take with 500 MG for a total of 625 MG. In addition, a PO dated 9/13/22, for Depakote 500 MG tablet; give 1 tablet (125 MG) by oral route 2 times per day. Take with 500 MG for a total of 625 MG. A review of the previous computer system eMAR reflected the administration of Depakote 125 MG and Depakote 500 MG together at 9 AM for a total dose of 625 MG. On 6/19/24 at 8:30 AM, the surveyor interviewed the DON who stated that the facility had changed computer systems on 6/11/24, and that all PO were transferred to the new computer system. On 6/20/24 at 10:45 AM, the survey team met with the DON who acknowledged that there was an error in the dosage of Depakote for Resident #5 that occurred on 6/18/24. The DON added that she was continuing to investigate how the entry error occurred. The DON added that she was reviewing with each nurse that administered medications regarding the Depakote PO for the total dose of 625 MG. A review of the facility's Medication Administration policy dated effective 12/23/23, included prior to medication administration Verify each medication preparation that the medication is the RIGHT DRUG, at the RIGHT DOSE, the RIGHT ROUTE, at the RIGHT RATE, at the RIGHT TIME, for the RIGHT CUSTOMER . Verify that the MAR reflects the most recent medication order . 3. On 6/18/24 at 8:45 AM, the surveyor observed RN #1 preparing to administer medications to Resident #51 which included 50 milliliters (ML) of methadone (a controlled medication used for opioid addiction) liquid with a concentration of 10 milligrams/10 ml. RN #1 stated that the methadone was obtained by the nursing supervisors from the methadone clinic on a weekly basis. RN #1 explained that the methadone was a controlled drug and had an inventory sheet (Methadone Chain of Custody Record) that was provided by the methadone clinic and had to be signed by the nurse and the resident for the appropriate date and all empty bottles were returned back to the clinic. At that time, the surveyor, with RN #1 reviewed the resident's Methadone Chain of Custody Record and the methadone bottles. RN #1 stated that there were seven bottles in a bag for Resident #51. RN #1 added that four were empty and three contained 50 ML of methadone. RN #1 stated that she was removing one bottle and signing the record for 6/18/24. The Methadone Chain of Custody Record revealed that on 6/17/24, there was no signature by a nurse for the removal of the methadone. At that time, RN #1 stated that she thought the Assistant Director of Nursing (ADON) was supposed to sign the form on 6/17/24. Resident #51 stated that they thought they had taken their methadone on 6/17/24, and had not remembered signing. A review of the eMAR for Resident #51 for Methadone administration on 6/17/24, revealed the electronic signature of the ADON. On 6/18/24 at 9:18 AM, the surveyor interviewed the ADON who stated that she was the nurse on the medication cart on 6/17/24. The ADON was unsure about administering methadone to Resident #51. The surveyor with the ADON, reviewed the Methadone Chain of Custody Record for Resident #51. The ADON then stated that she had not realized she was supposed to sign the record and should have signed the record for the removal of the methadone. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/19/24 at 8:30 AM, the surveyor interviewed the DON who stated that the resident's individual controlled drug sheet was to be signed when the controlled drug was removed from inventory so that there were no discrepancies. In addition, if there were any discrepancies then a supervisor was to be notified and the discrepancy was to be corrected immediately. A review of the facility's undated Schedule II Controlled Substance Medication policy included .When a CDS (controlled substance medication) is administered, in addition to following procedures for the charting of medications, the nurse must document on the declining inventory sheet the date of administration, the quantity administered, the amount of medication remaining and his/her initials . 4. On 6/18/24 at 8:45 AM, the surveyor observed RN #1 preparing to administer medications to Resident #51 which included 50 ML of methadone liquid with a concentration of 10 milligrams/10 ML. RN #1 stated that the methadone was obtained by the nursing supervisors from the methadone clinic on a weekly basis. RN #1 explained that the methadone was a controlled drug and had an inventory sheet (Methadone Chain of Custody Record) that was provided by the methadone clinic and had to be signed by the nurse and the resident for the appropriate date and all empty bottles were returned back to the clinic. At that time, the surveyor, with RN #1, reviewed the resident's Methadone Chain of Custody Record and the Methadone bottles. The RN #1 stated that there were seven bottles in a bag for Resident #51. The RN #1 added that four were empty and three contained 50 ML of methadone. RN #1 stated that she was removing one bottle and signing the record for 6/18/24. The Methadone Chain of Custody Record revealed that on 6/17/24, there was no signature by a nurse for the removal of the methadone. At that time, RN #1 stated that she thought the Assistant Director of Nursing (ADON) was supposed to sign the form on 6/17/24. Resident #51 stated that they thought they had taken their methadone on 6/17/24, and had not remembered signing. At that time, the surveyor with RN #1 reviewed the Narcotic Count Sheet (a monthly sheet for daily nurses' signatures to verify the inventory count of the controlled drugs at the change of shift) that corresponded to the First Floor nursing unit high side medication cart, which revealed that the sheet was not signed for 6/18/24 for the Nurse In. RN #1 stated that she had done an inventory count at the beginning of her shift with the outgoing nurse, but had forgotten to sign the Narcotic Count Sheet and proceeded to sign the sheet in front of the surveyor. RN #1 then stated that she had not told the ADON or any other supervisor about the missing signature for the methadone inventory because there was no discrepancy. Further review of the Narcotic Shift Count revealed that the following nurse signatures were missing: -6/4/24 11 PM Nurse Out -6/7/24 11 PM Nurse Out -6/10/24 11 PM Nurse In -6/11/24 7 AM Nurse Out (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-6/14/24 11 PM Nurse In -6/15/24 7 AM Nurse Out On 6/18/24 at 9:18 AM, the surveyor interviewed the ADON who stated that she was unaware of any discrepancies regarding the Narcotic Count shift to shift sheets. On 6/19/24 at 8:30 AM, the surveyor interviewed the DON who stated that the inventory count of the controlled drugs in the medication carts were completed before each shift and there were three shifts; 7 AM to 3 PM, 3 PM to 11 PM, and 11 PM to 7 AM. The DON explained that the inventory count was completed when the incoming nurse came in for their shift and the outgoing nurse was leaving their shift. The DON further explained that the Narcotic Count Sheet should be signed when the inventory was completed. The DON stated that the Narcotic Count Sheets should be thoroughly completed meaning there were no blanks. In addition, the DON stated that if there were any discrepancies, then that should be reported to a supervisor immediately. The DON explained that this system prevented any discrepancies from occurring with the controlled drug inventories. A review of the current facility's undated Schedule II Controlled Substance Medication policy included .when dispensing controlled substances An inventory count of all CDS (controlled drug substance) medications stored on each nursing unit shall be performed at each change of each shift by both the incoming and outgoing nurse. Both nurses are responsible for the count and must sign the inventory count form . 44833 5. On 6/18/24 at 11:45 AM, the surveyor, in the presence of RN #1, reviewed the First Floor nursing unit high side medication cart's narcotic logs. The following was observed: The June 2024 shift-to-shift Narcotic Count Sheet, RN #1 pre-signed for the 6/18 3 PM outgoing nurse. The Individual Patient Controlled Substance Administration Record (declining inventory log) for Resident #51's pregabalin 150 MG capsules (a controlled medication used to treat nerve and muscle pain) was missing Nurse Administering signatures for 6/14/24 9 AM and 9 PM doses. At that time, the surveyor interviewed RN #1, who confirmed she had pre-signed the outgoing nurse portion of the shift-to-shift stating I shouldn't have pre-signed informing the surveyor that this sheet was to be signed by the incoming and outgoing nurses together at shift change after a complete count of narcotics had been performed together. RN #1 further stated that there should be no missing signatures or documentation on the individual patient-controlled substance logs. On 6/18/24 at 12:25 PM, the surveyor, in the presence of the LPN, reviewed the Second Floor nursing unit high side medication cart's narcotic logs. The following was observed: Resident #9's tramadol HCl 50 MG tablet (controlled pain medication) declining inventory log was missing the administration time documentation for 5/30/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, the LPN stated that declining inventory logs should not have any missing documentation for doses that have been dispensed. On 6/18/24 at 12:53 PM, the surveyor interviewed UM/LPN #2 who stated there should be no missing documentation on narcotic declining inventory logs. On 6/19/24 at 8:30 AM, the surveyor interviewed the DON who stated that the inventory count of the controlled drugs in the medication carts were completed before each shift and there were three shifts; 7 AM to 3 PM, 3 PM to 11 PM and 11 PM to 7 AM. The DON explained that the inventory count was completed when the incoming nurse comes in for their shift and the outgoing nurse was leaving their shift and the Narcotic Count Sheet should be signed when the inventory completed. In addition, if there are any discrepancies then that should be reported to a supervisor immediately. The DON added that the individual resident controlled drug sheets were to be signed when the controlled drug was removed from inventory so that there were no discrepancies. Review of the facility's undated Schedule II Controlled Substance Medication included .a declining inventory sheet will be provided with each dispensed prescription for controlled dangerous medications .when CDS medication is administered, in addition to proper procedure for charting of medications, the nurse must document on the declining inventory sheet the date of administration, the quantity administered, the amount of medication remaining, and his/her initials. An inventory count of all CDs medications stored on each nursing unit shall be performed at each change of each shift by both the incoming and outgoing nurse. Both nurses are responsible for the count and must sign the inventory count form . NJAC 8:39-11.2(b), 29.2 (a)(d), 29.4(k), 29.7(c)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 Based on interview and record review it was determined that the facility failed to address the recommendations made by the Consultant Pharmacist (CP) in a timely manner. This deficient practice was identified for 4 of 5 residents reviewed for medication management (Resident #34, Resident #80, Resident #60, and Resident #61) and was previously cited during the facility's last standard survey on 10/20/22. The evidence was as follows: Refer F865 1. On 6/19/24 at 1:27 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the CP's recommendations for Resident #34 from March 2024 until present. According to the Admission Record (AR), Resident #34 was admitted to the facility with the diagnoses which included but was not limited to unspecified dementia with behavior disturbance and bipolar disorder (a type of mental illness). The quarterly Minimum Data Set (MDS), an assessment tool dated 3/30/24, reflected that the resident had severe cognitive deficits and had behaviors directed toward others. The MDS also reflected that the resident was dependent for activities of daily living (ADLs). On 6/20/24 at 9:00 AM, the DON provided the surveyor with Resident #34's CP recommendation reports for March 2024, April 2024, and May 2024. The CP recommendation dated 3/31/24, indicated that the medication Colace (stool softener) liquid should be diluted in 4 ounces of juice before administering. This recommendation was not completed or acted upon by the facility until 6/19/24. The CP recommendation dated 5/27/24, indicated the use of aspirin (ASA) 81 mg needed a diagnosis for use. The surveyor reviewed the Physician Order Summary sheet, and the recommendation was not acted upon by the facility. The ASA 81 mg continued not to have a diagnosis for the use. On 6/20/24 at 9:36 AM, the surveyor interviewed the DON who stated that the CP reports were sent to the facility through email by the CP, and the CP's recommendations were to be completed by the unit managers. The DON stated that an appropriate time for the CP's recommendations to be completed was within seven days of receiving. The DON could not explain why the recommendations provided from the CP from March 2024, April 2024 and May 2024 were not completed until 6/19/24 after surveyor inquiry. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/20/24 at 10:16 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN #1) for the First Floor nursing unit who stated that the CP report recommendations were usually completed by the unit manager, but could be assigned to the nurse on the unit or divided amongst the nursing staff to complete. UM/LPN #1 stated that an appropriate time to complete the CP's recommendation report was within one week. She continued to add that the unit managers usually received an email of the recommendations, but since switching over to the new electronic medical records (EMR), which was switched on 6/11/24, the DON received the recommendations. UM/LPN #1 revealed that the CP recommendations from March 2024, April 2024 and May 2024 were not given to the unit managers to complete until yesterday (6/19/24). On 6/20/24 at 12:24 PM, the surveyor interviewed the facility's CP who stated that she had been at the facility since March 2024, and it was important that the facility acted upon the pharmacy recommendations as soon as possible (ASAP) so that if there was a medication safety concern, it could be taking care of immediately. The CP stated that the facility needed more education because the new pharmacy consultant company was new to the facility and the staff was on a learning curve. 49094 2. On 6/19/24 at 1:27 PM, the surveyor requested from the LNHA and DON the CP's recommendations for Resident #80 from March 2024 until present. According to the Admission Record, Resident #80 was admitted to facility with diagnoses included bipolar disorder (a mental illness that causes unusual shifts in a person's mood) and schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly.) According to the most recent MDS dated [DATE], Resident #80 had a brief interview for mental status (BIMS) score of 15 out of 15, which indicated a fully intact cognition. A further review of the MDS revealed the resident had an active diagnosis of bipolar disorder, and received antipsychotic medications on a routine basis. On 6/20/24 at 9:00 AM, the DON provided the surveyor with Resident #80's CP's recommendation reports for March 2024 and April 2024. The CP recommendation dated 3/31/24, indicated that the medication pantoprazole 20 milligrams (MG) two tablets equal 40 MG daily has been administered since 1/18/24 for heartburn. It was recommended, if the resident was asymptomatic, to consider tapering to the pantoprazole to 20 MG daily, then discontinue the medication. This recommendation was not completed or acted upon by the facility until 6/19/24. The CP recommendation dated 3/31/24, indicated that the medication Combivent inhaler should include a frequency. This recommendation was not completed or acted upon by the facility until 6/19/24. The CP recommendation dated 3/31/24, indicated that the medication acetaminophen 325 MG (Tylenol) two tablets order indicated to administer as needed for complain of pain or elevated temperature. The acetaminophen order should be indicated for either pain or elevated temperature according to the CP. This recommendation was not completed or acted upon by the facility until 6/15/24 and 6/19/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The CP recommendation dated 3/31/24, indicated that the medication Xarelto 10 MG needed a correct diagnosis for use; long term use of anticoagulants was not a diagnosis. The surveyor reviewed the Physician Order Summary sheet, and the recommendation was not acted upon by the facility. The Xarelto 10 MG continued to have long term (current) use of anticoagulants as a diagnosis. The CP recommendation dated 3/31/24, indicated that the medication gabapentin 400 MG needed a clarified diagnosis from pain to neurological pain. This recommendation was not completed or acted upon by the facility until 6/19/24. On 6/20/24 at 9:36 AM, the surveyor interviewed the DON who stated that the CP reports were sent to the facility through email by the CP, and the CP's recommendations were to be completed by the unit managers. The DON stated that an appropriate time for the CP's recommendations to be completed was within seven days of receiving. The DON could not explain why the recommendations provided from the CP from March 2024, April 2024 and May 2024 were not completed until 6/19/24 after surveyor inquiry. On 6/20/24 at 12:24 PM, the surveyor interviewed the facility's CP who stated that she had been at the facility since March 2024, and it was important that the facility acted upon the pharmacy recommendations as soon as possible (ASAP) so that if there was a medication safety concern, it could be taking care of immediately. The CP stated that the facility needed more education because the new pharmacy consultant company was new to the facility and the staff was on a learning curve. 45209 3. On 6/19/24 at 1:27 PM, the surveyor requested from the LNHA and DON the CP's recommendations for Resident #60 from March 2024 until present. A review of the Admission Record face sheet (an admission summary) reflected that Resident #60 was admitted to the facility with diagnosis that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one entire side of the body) following cerebral infarction (stroke) affecting left dominant side, candidiasis (fungal infection) of skin and nail, and bipolar disorder. On 6/20/24 at 9:00 AM, the DON provided the surveyor with Resident #60's CP recommendation reports for March 2024 and May 2024. The CP recommendation dated 3/31/24, indicated that there were two pain assessment orders; please discontinue the order from 9/25/23 that was an needed (prn). This request was acknowledged with a handwritten done, but the facility could not provide documentation that it was completed in timely fashion. The CP recommendation dated 5/28/24, requested to do an order correction to allow for the results of temperature for acetaminophen prn for fever to be documented on the [medication administration record (MAR)]. This request was acknowledged with a handwritten done, but upon review of the physician's orders, the surveyor observed that the temperature could not be documented in the MAR. On the same recommendation, the CP requested that an order correction to allow for results of pain level for acetaminophen prn for pain to be documented on the MAR. These requests were acknowledged with a handwritten done, but the facility could not provide documentation that it was completed in timely fashion. (continued on next page)

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F 0756

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

On 6/20/24 at 9:36 AM, the surveyor interviewed the DON who stated that the CP reports were sent to the facility through email by the CP, and the CP's recommendations were to be completed by the unit managers. The DON stated that an appropriate time for the CP's recommendations to be completed was within seven days of receiving. The DON could not explain why the recommendations provided from the CP from March 2024, April 2024 and May 2024 were not completed until 6/19/24 after surveyor inquiry.

On 6/20/24 at 12:24 PM, the surveyor interviewed the facility's CP who stated that she had been at the facility since March 2024, and it was important that the facility acted upon the pharmacy recommendations as soon as possible (ASAP) so that if there was a medication safety concern, it could be taking care of immediately. The CP stated that the facility needed more education because the new pharmacy consultant company was new to the facility and the staff was on a learning curve.

4. On 6/19/24 at 1:27 PM, the surveyor requested from the LNHA and DON the CP's recommendations for Resident #61 from March 2024 until present.

A review of the Admission Record face sheet (an admission summary) reflected that Resident #61 was admitted to the facility with diagnosis that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one entire side of the body) affecting right dominant side, Type 1 diabetes mellitus with diabetic chronic kidney disease, and persistent mood disorder.

On 6/20/24 at 9:00 AM, the DON provided the surveyor with Resident #61's CP recommendation reports for May 2024.

The CP recommendation dated 5/27/24, requested to clarify Keppra (a seizure medication) by mouth every 12 hours and give at 9 AM and 9 PM. This request was acknowledged with a handwritten done, but upon review of the MAR (prior to surveyor inquiry) the order was not clarified until 6/20/24, when the administration times were adjusted per CP recommendation.

The CP recommendation dated 5/27/24, requested to clarify the diagnosis for acetaminophen prn for pain not fever. This request was acknowledged with a handwritten done, but upon review of the MAR (prior to surveyor inquiry) it was not updated and continued to have the fever diagnosis.

The CP recommendation dated 5/27/24, requested to do an order correction that allowed for blood sugar to be documented on the MAR. This request was acknowledged with a handwritten done, but upon review of the MAR (prior to surveyor inquiry) there was no space identified to allow documentation of the resident's blood sugar level.

On 6/20/24 at 9:36 AM, the surveyor interviewed the DON who stated that the CP reports were sent to the facility through email by the CP, and the CP's recommendations were to be completed by the unit managers. The DON stated that an appropriate time for the CP's recommendations to be completed was within seven days of receiving. The DON could not explain why the recommendations provided from the CP from March 2024, April 2024 and May 2024 were not completed until 6/19/24 after surveyor inquiry.

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NAME OF PROVIDER OR SUPPLIER Belle Care Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 439 Bellevue Avenue Trenton, NJ 08618	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/20/24 at 12:24 PM, the surveyor interviewed the facility's CP who stated that she had been at the facility since March 2024, and it was important that the facility acted upon the pharmacy recommendations as soon as possible (ASAP) so that if there was a medication safety concern, it could be taking care of immediately. The CP stated that the facility needed more education because the new pharmacy consultant company was new to the facility and the staff was on a learning curve. NJAC 8:39-29.3 (b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0757

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident’s drug regimen must be free from unnecessary drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 33106

Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to provide adequate monitoring for the use of psychoactive medications. This deficient practice was identified for 4 of 5 residents reviewed for unneccessray medications (Resident #34, #60, #61, and #80), and was evidenced by the following:

1. According to the Admission Record (AR), Resident #34 was admitted to the facility with the diagnoses which included unspecified dementia with behavior disturbance and bipolar disorder (a type of mental illness). The quarterly Minimum Data Set (MDS), an assessment tool dated 3/30/24, reflected that the resident had severe cognitive deficits and had behaviors directed toward others. The MDS also reflected that the resident was dependent for activities of daily living (ADLs) and was on psychoactive medications.

On 6/17/24 at 10:06 AM, the surveyor observed Resident #34 in bed sleeping. The surveyor also observed a Certified Nursing Assistant (CNA #1) sitting in a chair next to the resident's door. CNA #1 stated that the resident had behaviors such as touching others and required one to one (1:1) supervision.

On 6/18/24 at 9:59 AM, the surveyor observed Resident #34 in the room lying in bed. The surveyor did not observe the resident displaying any behaviors at this time. The resident was unable to be interviewed due to cognitive impairments, and the surveyor observed that the resident was being monitored 1:1 by a staff member in front of the resident's door.

The surveyor reviewed the residents Physician Order Summary sheet (POS) which reflected that Resident #34 was on the following psychoactive medications:

A physician's order (PO) dated 6/11/24, for sertraline (class of antidepressants called selective serotonin reuptake inhibitors (SSRIs)) 25 milligram (MG) tablet; administer 1 tablet orally one time a day related to the diagnoses of depression.

A PO dated 6/11/24, for divalproex sodium (used to treat the manic phase of bipolar disorder (manic-depressive illness)) 500 MG tablet; give 1 tablet orally at bedtime related to depression.

A PO dated 6/11/24, for divalproex sodium 250 MG tablet; give 1 tablet orally two times a day related to depression.

A PO dated 6/11/24, clonazepam (antianxiety) 0.5 MG tablet; give 0.25 mg orally three times a day related to anxiety disorder.

On 6/18/24 at 10:26 AM, the surveyor interviewed CNA #2 who stated that she worked for the agency. CNA #2 stated that Resident #34 was 1:1 supervision around the clock because the resident was at risk for falling. The CNA stated that the resident became combative at times with the staff and when she received report from the facility staff this morning, they told her that if the resident became too difficult to handle, to come get help from additional staff members.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24 at 10:30 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that Resident #34 was on 1:1 supervision for behaviors such as picking up objects and eating them. The LPN stated that the facility provided the resident with crossword puzzles to occupy their time as a distraction. She stated that she had not noticed on the new electronic medical record (EMR) that behavior monitoring was being documented for Resident #34. The LPN stated that behaviors were documented on the Progress Notes, however there were no episodic behaviors documented on the resident's Medication Administration Record (MAR) or Treatment Administration Record (TAR). The surveyor reviewed the resident's MAR and TAR and there was no episodic documentation on Resident #34s targeted behaviors. On 6/18/24 at 10:35 AM, he surveyor interviewed the Unit Manager/LPN (UM/LPN) for the First Floor nursing unit who stated that Resident #34 was on 1:1 supervision for behaviors such as touching and grabbing other residents and eats things that were not on the resident's diet. The UM/LPN stated that behaviors were charted by exception in the Progress Notes, and that there was no episodic documentation of behavior monitoring in the MAR or TAR. She also stated that she did not know if a monthly psychotropic summary was completed for Resident #34. The Consultant Pharmacist (CP) report dated 5/27/24, indicated that the resident was on psychotropic medications and recommended, to please monitor and document target behaviors (number of episodes that occurred) and side effects daily when the resident was on psychotropic medications. Please complete monthly psychotropic reviews (none found in the EMR). The surveyor did not find that the recommendation was followed in the resident's electronic medical record. On 6/20/24 at 9:42 AM, the surveyor interviewed the Director of Nursing (DON) who stated behaviors were documented in the Progress Notes. The DON stated that targeted behaviors were reviewed in the Progress Notes and how many times a resident experienced a targeted behavior. The DON stated that there should be a monthly Psychotropic Summary Sheet (PSS) and indicated that it would be documented in the Progress Notes. The DON stated that as the behaviors were occurring, then the behavior were documented in the Progress Notes. The DON added that side effects from medications should also be documented in the Progress Notes. On 6/20/24 at 11:24 AM, the DON could not provide the surveyor with PSS or documentation that the psychotropic drugs summaries were being documented monthly. No additional information was provided. 45209 2. A review of the Admission Record face sheet (an admission summary) reflected that Resident #61 was admitted to the facility with diagnosis that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one entire side of the body) affecting right dominant side, Type 1 diabetes mellitus with diabetic chronic kidney disease, and persistent mood disorder. The surveyor reviewed the resident's Physician Order Summary sheet (POS) which reflected that Resident #61 was on the following psychoactive medications: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A PO dated 6/10/24, for buspirone (a medication primarily used to treat anxiety disorders) 10 MG; give 1 tablet by mouth two times a day for anxiety. A PO dated 6/11/24, for quetiapine 150 MG (a medication used to treat certain mental/mood disorders); give 1 tablet by mouth at bedtime for schizophrenia (a mental disorder characterized by significant alterations in perception, mood, thoughts, and behaviors). A PO dated 6/11/24, for trazodone (antidepressant that belongs to a group of drugs called serotonin receptor antagonists and reuptake inhibitors ([NAME]) used to treat major depressive disorder) 50 MG; give 1/2 tablet by mouth at bedtime for depression. A PO dated 6/11/24, for trazodone 50 MG; give 1 tablet by mouth at bedtime for depression. Give with Trazodone 50mg to equal 75mg. The CP report dated 5/27/24, indicated that the resident was on psychotropic medications and recommended to please monitor and document target behaviors (number of episodes that occurred) and side effects daily when the resident is on psychotropic medications. Please complete monthly psychotropic reviews. There were none seen. The surveyor did not find that the recommendation was followed in the resident's electronic medical record. The surveyor reviewed the resident's MAR and TAR and there was no episodic documentation on Resident #61s targeted behaviors. On 6/20/24 at 9:42 AM, the surveyor interviewed the Director of Nursing (DON) who stated behaviors were documented in the Progress Notes. The DON stated that targeted behaviors were reviewed in the Progress Notes and how many times a resident experienced a targeted behavior. The DON stated that there should be a monthly Psychotropic Summary Sheet (PSS) and indicated that it would be documented in the Progress Notes. The DON stated that as the behaviors were occurring, then the behavior were documented in the Progress Notes. The DON added that side effects from medications should also be documented in the Progress Notes. On 6/20/24 at 11:24 AM, the DON could not provide the surveyor with PSS or documentation that the psychotropic drugs summaries were being documented monthly. No additional information was provided. 3. A review of the Admission Record face sheet reflected that Resident #60 was admitted to the facility with diagnosis that included, but not limited to hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one entire side of the body) following cerebral infarction (stroke) affecting left dominant side, candidiasis (fungal infection) of skin and nail, and bipolar disorder. The surveyor reviewed the resident's POS which reflected that Resident #60 was on the following psychoactive medications: A PO dated 4/14/24, for buspirone 15 MG; give 1 tablet three times a day for depression related to major depressive disorder, single episode, mild. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A PO dated 5/5/24, for divalproex sodium 125 MG; give 3 capsule orally one time a day for bipolar disorder related to bipolar disorder, current episode hypomanic. A PO dated 5/24/24, divalproex sodium 250 MG; give 1 tablet orally at bedtime for bipolar disorder related to bipolar disorder. A PO dated 5/25/24, divalproex sodium 500 MG; give 1 tablet orally at bedtime for bipolar disorder give with 250 MG for total dose of 750 MG. A PO dated 6/23/24, for trazodone 100 MG; give 1 tablet orally at bedtime related to insomnia. The surveyor reviewed the resident's MAR and TAR and there was no episodic documentation on Resident #60s targeted behaviors. The CP report dated 5/27/24, indicated that the resident was on psychotropic medications and recommended to please monitor and document target behaviors (number of episodes that occurred) and side effects daily when the resident is on psychotropic medications. Please complete monthly psychotropic reviews. There were none seen. The surveyor did not find that the recommendation was followed in the resident's electronic medical record. On 6/20/24 at 9:42 AM, the surveyor interviewed the Director of Nursing (DON) who stated behaviors were documented in the Progress Notes. The DON stated that targeted behaviors were reviewed in the Progress Notes and how many times a resident experienced a targeted behavior. The DON stated that there should be a monthly Psychotropic Summary Sheet (PSS) and indicated that it would be documented in the Progress Notes. The DON stated that as the behaviors were occurring, then the behavior were documented in the Progress Notes. The DON added that side effects from medications should also be documented in the Progress Notes. On 6/20/24 at 11:24 AM, the DON could not provide the surveyor with PSS or documentation that the psychotropic drugs summaries were being documented monthly. No additional information was provided. 49094 5. According to the Admission Record, Resident #80 was admitted to facility with diagnoses including but not limited to: Bipolar Disorder (a mental illness that causes unusual shifts in a person's mood) and Schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly.) According to the most recent Minimum Data Set (MDS), an assessment tool dated 04/25/24, revealed Resident #80 had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating cognitively intact cognition. Section I of the MDS revealed Resident #80 had an active diagnosis of Bipolar Disorder. According to section N of the MDS Resident #80 receives antipsychotic medications on a routine basis. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the initial tour of the 2nd floor on 06/17/24 at 10:52 AM, the surveyor observed resident #80 lying in bed awake and alert. Resident #80 was receiving humidified oxygen at 3 liters per minute (lpm) via nasal cannula. The surveyor did not observe the resident displaying any behaviors at this time. The surveyor reviewed the residents Physician Order Summary sheet (POSS) which reflected that Resident #80 was on the following psychoactive medications: 1.) The POSS reflected an order dated 04/11/2024, for Divalproex sodium (used to treat the manic phase of bipolar disorder (manic-depressive illness) 125MG CAPS-HD, give 3 capsules orally two times a day related to Bipolar Disorder. 2.) The POSS reflected an order dated 05/07/2024, for Lurasidone (class of antipsychotic used to treat schizophrenia and bipolar depression) TAB 40 MG, administer 3 tablets orally at bedtime for psychotic disorder related to other psychotic disorder not due to a substance or known physiological condition. The surveyor reviewed the resident's MAR and TAR and there was no episodic documentation on Resident #80's targeted behaviors. On 06/20/24 at 09:42 AM, in the presence of the survey team the Director of Nursing (DON) stated that resident's behaviors are documented in the progress notes. The DON stated that targeted behaviors would have to be reviewed in the progress notes and how many times a resident experienced a targeted behavior. She stated that there should be a monthly psychotropic summary sheet (PSS) and indicated that it would be documented in the progress notes. The DON stated that as the behaviors were occurring then the behavior should be documented in the progress notes. She added that side effects from medications should also be documented in the progress notes. On 06/20/24 at 11:24 AM, the DON could not provide the surveyor with PSS or documentation that the psychotropic drugs summaries were being documented monthly. On 06/24/2024 at 11:39 AM, the facility could not provide any additional information. The facility policy titled, Medication Use dated 09/2017 indicated that behavior monitoring for all residents on antipsychotic, antianxiety, antidepressant hypnotic medications will be incorporated with the MAR monthly. The nurse must monitor their subsequent effects on the resident every shift. Specific behaviors to be monitored will be identified for residents on antianxiety and antipsychotic medications. The policy also indicated that monthly psychotropic summaries would be completed monthly describing resident progress or deterioration, including summary of psychotropic medications being used and their subsequent effects to the resident/patient. The summary would include psychiatrist/psychologist visits and any plan for reduction and/or continuation of the medications.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 34033 Based on observation, interview, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the morning medication administration observation on 6/18/24, the surveyor observed two (2) nurses administer medications to three (3) residents. There were 29 opportunities, and three (3) errors were observed which calculated to a medication administration error rate of 10.3%. The deficient practices were identified for 2 of 3 residents, (Resident #51 and #5), that were administered medications by 2 of 2 nurses that were observed. The facility was previously cited for this during their last standard survey. The deficient practices were evidenced by the following: 1. On 6/18/24 at 8:28 AM, during the morning medication administration pass, the surveyor, observed the Registered Nurse (RN #1) preparing nine (9) medications for Resident #51 which included a 200 milligram (MG) tablet of lamotrigine (Lamictal). RN #1 stated that the medication card of Lamictal 200 MG tablets for Resident #51 was empty, and that she did not have any to administer to Resident #51 for the 9 AM dose. RN #1 stated that she would have to call the provider pharmacy and tell the Unit Manager/Licensed Practical Nurse (UM/LPN #1). RN #1 stated that she was an agency nurse and had not worked at the facility for months and could not speak to why the medication was not available in the cart. At that time, Resident #51 stated that they were not upset that the Lamictal was not available because they received their other medications. The surveyor reviewed the medical record for Resident #51. A review of the Admission Record face sheet (an admission summary) revealed diagnoses that included bipolar disorder (a mental health disorder), anxiety disorder and psychoactive substance abuse. A review of a comprehensive Minimum Data Set (MDS), an assessment tool dated 4/29/24, reflected the resident had a brief interview for mental status (BIMS) score of 15 out of 15, indicating that the resident had an intact cognition. A review of the Order Summary Report revealed a physician's order (PO) with a start date of 6/6/24, for Lamictal 200 MG; administer 1 tablet orally two times a day for bipolar disorder. A review of the backup inventory list that was stored in the facility was provided by the Director of Nursing (DON). The list reflected that Lamictal 25 MG tablets were in supply with eight tablets On Hand. On 6/18/24 at 11:27 AM, the surveyor interviewed UM/LPN #1 who stated that she was unaware that Resident #51 had a medication that was not available. On 6/18/24 at 11:41 AM, the surveyor interviewed RN #1 who stated that she had not yet told UM/LPN #1 the resident's Lamictal was not available. Resident #51 had not received the Lamictal as ordered by the physician. (ERROR #1) (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/19/24 at 8:30 AM, the surveyor interviewed the DON who acknowledged that the facility's Medication Administration policy had not included a procedure for medications that were not available. The DON stated that when a medication was not available during medication administration, then a supervisor should be contacted. The DON further explained that the in house backup supply would then be checked, and the provider pharmacy called because the medication should be available within one hour. The DON added if the medication was not able to be available within one hour, then the physician must be called for follow up orders and documented in the Nursing Progress Notes. The DON stated that the medication administration computer system was recently changed but that nurses should still follow nursing procedures. A review of the Nursing Progress Notes for 6/18/24 and 6/19/24, did not include Progress Notes regarding the Lamictal not being administered. On 6/19/24 at 2:57 PM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone who stated that she had started as the CP in March of 2024. The CP added that she had not done any med passes on nurses or inservices for medication administration yet. On 6/20/24 at 1:21 PM, the survey team met with the DON and the Licensed Nursing Home Administrator (LNHA). The DON stated that there were no medication administration observations performed with RN #1, and the facility had not done any inservices on medication administration recently. 2. On 6/18/24 at 8:59 AM, during the morning medication administration pass, the surveyor, observed RN #2 preparing eight (8) medications for Resident #5 which included three (3) tablets of risperidone (Risperdal) 0. 25 MG for a total of 0.75 MG. RN #2 stated that she did not have the Risperdal 0.25 MG tablets in the medication cart to administer to Resident # 5 that was due at 9 AM. On 6/18/24 at 9:17 AM, the surveyor interviewed RN #2 who stated that according to the computer the Risperdal was on order. RN #2 explained that the ordering system can be done electronically with the provider pharmacy. RN #2 stated that she was an agency nurse and had not worked at the facility for months, so she could not speak to when the Risperdal would be available. RN #2 stated that she would have to check the backup supply to see if Risperdal was available or call the provider pharmacy to see when the Risperdal would be delivered. The RN also stated that she would have to tell UM/LPN #2 and might have to call the physician if the Risperdal was not available to be administered for the 9 AM dose to obtain follow up orders. The surveyor reviewed the medical record for Resident #5. A review of the Admission Record face sheet revealed the resident had diagnoses that included bipolar disorder (a mental health disorder) and generalized anxiety disorder. A review of the Order Summary Report revealed a PO with a start date of 6/7/24, for Risperdal oral tablet 0. 25 MG; give 3 tablets by mouth in the morning for bipolar disorder; 3 tabs = 0.75 MG. On 6/18/24 at 11:08 AM, the surveyor interviewed RN #2 who stated that she had not yet checked the backup supply or called the provider pharmacy. On 6/18/24 at 12:23 PM, the surveyor interviewed UM/LPN #2 who stated that she was unaware of a medication not being available for Resident #5. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/18/24 at 12:34 PM, the surveyor interviewed RN #2 who stated that she had not yet checked the backup supply, told the UM or called the physician. Resident #5 had not received the Risperdal as ordered by the physician. (ERROR #2) A review of the backup inventory list that was stored in the facility was provided by the DON indicated that Risperdal tablets was not on the list. On 6/19/24 at 8:30 AM, the surveyor interviewed the DON who acknowledged that the Medication Administration policy had not included a procedure for medications that were not available. The DON stated that when a medication was not available during medication administration, then a supervisor should be contacted. The DON further explained that the backup supply would then be checked, and the provider pharmacy called because the medication should be available within one hour. The DON added if the medication was not able to be available within one hour, then the physician must be called for follow up orders and documented in the Nursing Progress Notes. The DON stated that the medication administration computer system was recently changed but that nurses should still follow nursing procedures. A review of the Nursing Progress Notes for 6/18/24 and 6/19/24, included no Progress Notes regarding the Risperdal not being administered. On 6/19/24 at 2:57 PM, the surveyor interviewed the CP via the telephone who stated that she had started as the CP in March of 2024. The CP added that she had not done any med passes on nurses or inservices for medication administration yet. On 6/20/24 at 1:21 PM, the survey team met with the DON and the LNHA. The DON stated that there were no medication administration observations performed with RN #2 and the facility had not done any inservices on medication administration recently. 3. On 6/18/24 at 8:59 AM, during the morning medication administration pass, the surveyor, observed RN #2 preparing eight (8) medications for Resident #5 which included a 125 MG tablet of divalproex sodium delayed release (Depakote) (a medication used for mood stabilization). On 6/18/24 at 9:08 AM, the surveyor observed RN #2 administer seven (7) medications to Resident #5 which included the Depakote 125 MG tablet. (As noted above the Risperdal was not administered.) Upon returning to the medication cart, the surveyor observed the RN #2 electronically sign the Medication Administration Record (MAR) for Resident #5 for all the highlighted medications that were due for 9 AM. The surveyor reviewed the medical record for Resident #5. A review of the Admission Record revealed diagnoses that included bipolar disorder (a mental health disorder) and generalized anxiety disorder. A review of the Order Summary Report revealed a PO with a start date of 6/6/24, for Depakote 125 MG tablet; give 1 tablet orally two times a day for bipolar disorder. Give with 500 MG for a total dose of 625 MG. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the Order Summary Report revealed PO with an active date of 4/29/24, and a start date of 6/30/24, for Depakote 500 MG tablet; give 1 tablet orally two times a day for bipolar disorder. Give with 125 MG for a total dose of 625 MG. A review of the June 2024 MAR revealed the above PO for Depakote 125 MG. In addition, the MAR revealed a PO dated 6/30/24, for Depakote 500 MG tablet; give 1 tablet orally two times a day for bipolar disorder. Give with 125 MG for a total dose of 625 MG. The MAR reflected all June dates with an X until 6/30/24. On 6/18/24 at 12:23 PM, the surveyor interviewed UM/LPN #2 regarding the dose of Depakote that was to be administered at 9 AM to Resident #5. UM/LPN #2 checked the electronic records for Resident #5 and stated that the facility had changed electronic charting systems recently and was checking both systems. UM/LPN #2 then verified that the dose of Depakote that Resident #5 was to receive at 9 AM was a total of 625 MG. UM/LPN #2 explained that there was a PO for Depakote 125 MG and Depakote 500 MG to be administered together for a total dose of 625 MG. UM/LPN #2 then reviewed the current MAR and stated that the Depakote 500 MG order was entered incorrectly because the PO had a start date of 6/30/24, and should have been started on 6/11/24, with the Depakote 125 MG PO. UM/LPN #2 added that the Depakote 125 MG PO had instructions regarding the total dose but that when the electronic system started on 6/11/24, the Depakote 500 MG dose would not be highlighted for administration at 9 AM until 6/30/24. UM/LPN #2 was unable to speak to how the PO was entered incorrectly. (ERROR #3) A review of the previous computer system Physician's Orders revealed a PO dated 9/13/22, for Depakote 125 MG tablet, delayed release; give 1 tablet (125 MG) by oral route 2 times per day. Take with 500 MG for a total of 625 MG. In addition, a PO dated 9/13/22, for Depakote 500 MG tablet; give 1 tablet (125 MG) by oral route 2 times per day. Take with 500 MG for a total of 625 MG. A review of the previous computer system MAR reflected the administration of Depakote 125 MG and Depakote 500 MG together at 9 AM for a total dose of 625 MG. On 6/19/24 at 8:30 AM, the surveyor interviewed the DON who stated that the facility had changed computer systems on 6/11/24, and that all PO were transferred to the new computer system. On 6/20/24 at 10:45 AM, the survey team met with the DON who acknowledged that there was an error in the dosage of Depakote for Resident #5 that occurred on 6/18/24. The DON added that she was continuing to investigate how the entry error occurred. The DON also stated that there were no medication administration observations performed on RN #2 and there were no recent medication administration inservices completed. A review of the facility's Medication Administration policy dated 12/23/23, included .Verify each medication preparation that the medication is the RIGHT DRUG, at the RIGHT DOSE, the RIGHT ROUTE, at the RIGHT RATE, at the RIGHT TIME, for the RIGHT CUSTOMER .Verify that the MAR reflects the most recent medication order .Medications are administered in a timely fashion as specified by policy . NJAC 8:39-11.2(b), 29.2(d)

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	315124	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belle Care Nursing and Rehabilitation Center	439 Bellevue Avenue Trenton, NJ 08618

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44833 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) properly store medications, b.) maintain clean and sanitary medication storage areas, and c.) properly label opened multidose medications. This was observed in 2 of 2 observed medication carts on 2 of 2 nursing units and was previously cited during the facility's last standard survey on [DATE]. The evidence was as follows: Refer F865 On [DATE] at 10:44 AM, during initial tour of the facility, the surveyor observed in Resident room [ROOM NUMBER], which was occupied by four residents, a box of sodium chloride (NaCl) inhalation solution individual vials (medication used to treat lung disease) stored unsecured and in the open, on top of a table next to the room door. On [DATE] at 11:45 AM, the surveyor, in the presence of the Registered Nurse (RN), reviewed the First Floor nursing unit's high side nursing medication cart, and observed the following: 32 unidentifiable loose pills of various colors, shapes, and sizes. Two opened foil packages of ipratropium bromide 0.5 milligrams (MG) and albuterol sulfate 3 MG inhalation solution individual vials (a medication used to treat lung disease), one dated with an opened date of [DATE] and the second with opened date [DATE]. The foil packages included printed manufacture instructions that indicated a one-week expiration once opened. At that time, the RN confirmed that the two foil packages of inhalation solution should have been discarded and there should have been no loose pills in the medication cart. On [DATE] at 12:25 PM, the surveyor, in the presence of the Licensed Practical Nurse (LPN), reviewed the Second Floor nursing unit's high side medication cart, and observed ten unidentifiable loose pills of various colors, shapes, and sizes. At that time, the LPN confirmed that there should not be any loose pills in the medication cart. On [DATE] at 10:05 AM, the surveyor, in the presence of the survey team and the Licensed Nursing Home Administrator, interviewed the Director of Nursing (DON) who stated that there should not be any medications stored in a resident's room, and that the medication observed in Resident room [ROOM NUMBER] should not be there. The DON further confirmed that there should be no loose pills in the medication carts, and that medication identified as expired should not have been in the cart and should have been discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Medication Storage/Labeling policy with initiated date of February 2019 included . medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . N.J.A.C. 8:,d+[DATE].4

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 48964 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to serve residents a nourishing snack when there was more than a fourteen-hour span of time between the dinner and breakfast mealtimes. This deficient practice was identified for 5 of 7 residents during the Resident Council meeting (Resident #23, #55, #61, #74, and #79), and was evidenced by the following: On 6/19/24 at 9:15 AM, the surveyor in the presence of the District Operations (Regional Food Service Director; Regional FSD) observed labeled snacks in the reach-in refrigerator in the kitchen. The Regional FSD stated that the facility supplied approximately seventy-five snacks in total for three snack times a day for residents. The Regional FSD continued that not all residents received snacks; some had physician ordered snacks that were sent up at a certain time and labeled, and then the facility provided a few additional sandwiches if a resident wanted. The Regional FSD confirmed there was not enough snacks for every resident, and not every resident received a hour of sleep (HS) snack. On 6/19/24 at 10:03 AM, the surveyor conducted a Resident Council meeting which included seven residents (Resident #3, #13, #23, #55, #61, #74, and #79). Five of the seven residents stated that they did not receive HS snacks. They stated that you must be on the list to receive HS snacks. A review of the facility mealtimes provided by the facility on entrance, indicated that breakfast was served at 7:30 AM and dinner was served at 4:30 PM; which was fifteen hours in between dinner and breakfast. On 6/20/24 at 9:17 AM, the surveyor interviewed the Unit Manager/Licensed Practical Nurse (UM/LPN #1) who stated that the HS snacks arrived at the nursing unit before 7:00 PM, and some were labeled for particular residents and there were also extra. UM/LPN #1 stated that the certified nursing aides (CNAs) handed out the snacks, and there were never any snacks left at the end of the night. On 6/20/24 at 9:22 AM, the surveyor interviewed the LPN who stated that HS snacks were distributed by the CNAs and nurses, and there were no signature sheets to sign that a resident received a snack. On 6/20/24 at 9:29 AM, the surveyor interviewed the Dietary Aide who stated that there was a list with names and snacks that were sent to the nursing units. On 6/20/24 at 9:34 AM, the surveyor interviewed UM/LPN #2 who stated that snacks were not signed for, and there were never any leftover snacks. On 6/20/24 at 10:06 AM, the surveyor interviewed the Director of Nursing (DON) who stated that snacks were served at 10:00 AM, 2:00 PM, and evening. There were specific snacks for some residents and then extra snacks also. The DON stated that whoever wanted a snack, it was provided. She further stated that she was not going to say the staff go door to door, but they offered snacks to the residents. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/20/24 at 11:01 AM, the surveyor interviewed the FSD who confirmed there was approximately seventy-five snacks made throughout the day. The FSD continued that some snacks were labeled with residents' names who had a physician's ordered snack, but there were not enough snacks for everyone to have at night. The FSD stated the kitchen provided sandwiches, cookies, crackers, juice, and milk as snacks. The FSD provided the surveyor with a list of residents who received snacks throughout the day. A review of the list provided by the FSD revealed that Resident #3 and Resident #13 had a physician's ordered snack. On 6/20/24 at 1:24 PM, the surveyor in the presence of the Licensed Nursing Home Administrator (LNHA), DON, and survey team informed the facility of the identified concern, and asked what was considered a nourishing snack. The DON stated the facility provided peanut butter and jelly sandwiches or applesauce, but the LNHA could not speak to it. On 6/25/24 at 11:40 AM, the surveyor interviewed the Registered Dietitian (RD) who stated residents received HS snacks upon request or by physician order. The RD stated there was no formal policy regarding snacks, but not everyone received one, and he was unsure about the regulation regarding the time in between dinner and breakfast. When asked what a nourishing snack was considered, the RD stated eight ounces of milk, whole sandwich, or pudding. A review of facility provided Snack Program Policy dated revised October 2022, included .All residents are offered snacks upon admissions and continuously throughout their stay .HS (Hour of Sleep):1. Dietary Service employees prepare, label, and date snacks including the use by date, according to the menu and in sufficient quantity to serve all residents; 2. Dietary Service delivers snacks to nursing units/stations at specified times; 3. Nursing or designated staff offers snack to each resident;4. Snacks are passed within 15 minutes of delivery to the unit or are properly stored at the nursing station and offered at a later time . NJAC 8:39-17.2 (f)(1)(i-ii)

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

38080

Based on observation and interview, it was determined that the facility failed to a.) maintain multiuse food-contact surface cutting board in a manner to prevent microbial growth; and b.) maintain storage and preparation areas in a sanitary manner. This deficient practice was evidenced by the following:

On 6/19/24 at 9:15 AM, the surveyor conducted a kitchen tour with the Regional District Operations (RDO) and observed the following:

1. In the walk-in freezer, the vinyl strip curtains located in the entrance to the freezer, there were only two curtain strips. These curtains protect the inside of the freezer from outside dust particles as well as keep the cold air from escaping the freezer when the door was opened. There was also ice accumulation around the door frame. The RDO acknowledged the freezer needed vinyl curtains and there should not be ice around the door frame. The RDO stated the vinyl curtains maintained the freezer temperature and the ice was a result of the temperature changing in the freezer.

2. At 9:30 AM, the Food Service Director (FSD) joined the tour, and they observed several large multi-colored cutting boards on the storage rack that were pitted and discolored. The FSD acknowledged the cutting boards needed to be changed.

3. Around the preparation sink on the metal work surface, a pinkish colored liquid. The [NAME] stated he discarded the juice from the bag of chicken he was preparing in the sink, and the juice must have gotten on the surface. The FSD and [NAME] both acknowledged the chicken juice needed to be cleaned up and sanitized immediately.

On 6/26/24 at 10:34 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON), Assistant Director of Nursing (ADON), and survey team acknowledged these findings.

A review of the facility's Cutting Board Care and Use Policy dated revised October 2023, included once cutting boards develop hard to clean grooves or are excessively worn, they will be replaced.

A review of the facility's Maintaining and Cleaning Equipment policy dated revised March 2024, included the Director of Dining Services or designee will ensure all equipment is maintained, kept clean, and in sanitary condition before and after each use .

NJAC 8:39-17.2(g)

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F 0835

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Administer the facility in a manner that enables it to use its resources effectively and efficiently.

38080

Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to ensure staff implemented facility policies and procedures to ensure a.) residents were provided with care and services to achieve their highest practical wellbeing and b.) their Quality Assurance and Performance Improvement (QAPI) Program was being implemented to ensure sustainability with previously cited deficiencies. This deficient practice was identified on 2 of 2 nursing units, and was evidenced by the following:

Refer F600, F610, F641, F725, F756, F761, F838, F865, F881, F882

A review of the Administrator's job description provided by the facility revealed the following:

Administrator is responsible for planning and is accountable for all activities and departments at [name redacted] subject to rules and regulations promulgated by government agencies to ensure proper health care services to residents. The Administrator administers, directs, and coordinates all activities of the facility to assure that the highest degree of care is constantly provided to the residents .

Responsibilities/Accountabilities included but not limited to: implements [name redacted] objectives as determined and directed by the governing body; interprets practices within guidelines and recommends changes as necessary; superintends physical operations of the facility; concerns his/herself with the safety of all nursing facility residents in order to minimize the potential for fire and accidents; oversees and guides department managers in the development and use of departmental policies and procedures; and ensure that residents and families receive the highest level of service in a caring and compassionate atmosphere which recognizes the individuals needs and rights .

1. During entrance conference on 6/17/24 at 10:00 AM, the surveyor asked the LNHA and Director of Nursing (DON) who the facility's Infection Preventionist (IP) was, and the facility did not have an IP for two or three months, that the Assistant Director of Nursing (ADON), two unit managers, and herself reviewed antibiotic stewardship and inserviced staff on infection control. The surveyor requested a copy of their infection control certifications.

On 6/19/24 at 1:36 PM, the surveyor interviewed the DON who stated she did not have a certification in infection control; but she reviewed infection control with the ADON who also was not certified. The DON stated only the Unit Manager/Licensed Practical Nurse (UM/LPN #1) had an infection control certification. The DON stated the unit managers provided the antibiotic stewardship information to the ADON who reviewed, summarized, and completed the monthly report, and the ADON in-serviced staff on infection control.

On 6/20/24 at 12:36 PM, the surveyor interviewed the ADON who stated the facility had no IP since April of 2024, everyone was pitching in with infection control. The ADON stated she had just completed May's antibiotic stewardship review yesterday.

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F 0835

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

On 6/25/24 at 10:58 AM, the surveyor re-interviewed the ADON who confirmed she had no infection control certification, and she was responsible for providing staff with infection control training.

On 6/25/24 at 1:27 PM, the surveyor in the presence of the DON, Regional Nurse, and survey team, asked the LNHA what their role was. The LNHA stated their role was to oversee operations for the facility, all departments and department heads to ensure residents received the services, were safe, and needs were met.

2. On 6/18/24 at 7:57 AM, during the medication administration observation, the surveyor observed 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 UM/LPN #2 because she was an agency 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 AM (8 AM) and 9:00 AM (9 AM) medications for four sampled residents, (Resident #32, #61, #79, and #84), and six unsampled residents, (unsampled Resident #1, #2, #3, #4, #5, #6). RN #1 stated that she had already administered the morning medications to those residents and needed to sign the eMAR. RN #1 explained that she administered morning medications to the residents earlier because they were a priority since the residents were either diabetic, on dialysis or had a feeding tube (surgical tube inserted into the stomach), and she had not had a chance to sign the eMAR.

On 6/18/24 at 8:45 AM, the surveyor observed RN #1 administer and electronically sign for medications that were administered to Resident #51.

A review of the eMARs for Resident #89, #51, #32, #61, #79, #84 and the six unsampled residents revealed that the initials for the 8 AM and 9 AM medications on 6/18/24 had the electronic signature initials for UM/LPN #2.

On 6/18/24 at 11:27 AM, the surveyor interviewed UM/LPN #2 at the nurse's station, who stated that she had given RN #1 her login because there was a problem this morning. In addition, UM/LPN #1 stated that medications should be signed for immediately after administering them to the resident.

At that time, the Assistant Director of Nursing (ADON) was at the nurse's station and confirmed UM/LPN #2 should not have given RN #1 her login password. The ADON stated that when the computer system changed on 6/11/24, the staff were trained on how to use the system, but that agency nurses were already familiar with the system.

On 6/25/24 at 1:27 PM, the surveyor in the presence of the DON, Regional Nurse, and survey team, asked the LNHA what their role was. The LNHA stated their role was to oversee operations for the facility, all 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 LNHA and DON how the facility's staff was, and the LNHA stated that the facility relied heavily on Agency staffing.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/18/24 at 8:02 AM, the surveyor conducted an incontinence tour on the Second Floor nursing unit accompanied by the Um/LPN #1 and observed the following: The surveyor and UM/LPN #1 entered Resident #147's room who was observed lying in bed. UM/LPN #1 asked the resident if she could check their incontinent brief and the resident gave UM/LPN #1 permission. The surveyor observed that the resident's incontinent brief was dry and the chuck (protective bed pad) that was directly under the resident was dry, however the fitted sheet located under the chuck had a large brown/yellow stain that smelled like urine and contained some dry brown stains which UM/LPN #1 identified as bowel movement (bm). UM/LPN #1 was interviewed at that time, and stated that the Certified Nursing Aide (CNA) that was assigned to care for Resident #32 should have changed the resident's sheet when performing incontinence care and should not have left a urine-soaked sheet on the resident's bed. UM/LPN #1 stated that the Agency CNA that cared for the resident on 11:00 PM to 7:00 AM shift must have left the dirty sheet on the resident's bed because the CNA (CNA #1) that came in that morning just got to the unit and had not made rounds yet. UM/LPN #1 stated that incontinence rounds were completed by the CNA every two hours. The surveyor observed the resident's skin during the tour and the resident's skin was free of skin breakdown. A review of the CNA Assignment sheet for 6/18/24, revealed that for the resident census of 47, there were five assigned CNAs. CNA #1 had thirteen assigned residents to care for. On 6/18/24 at 8:45 AM, the surveyor conducted an incontinence tour on the First Floor nursing unit with a Licensed Practical Nurse (LPN) and observed the following: On 6/18/24 at 9:00 AM, the surveyor accompanied the LPN into Resident #32's room observed the resident lying in bed and was non-verbal. The resident's incontinence brief was observed to be very wet with urine and the sheets were observed with a large urine stain that had a strong smell of urine. The LPN was interviewed at the time and confirmed that the stain the surveyor observed on the resident's sheet was urine and that the resident's incontinence brief should have been changed and the entire bed linen should have been changed. The resident's skin was observed, and the resident's skin was intact and free of breakdown. On 6/18/24 at 9:10 AM, the surveyor interviewed UM/LPN #2 for the First Floor nursing unit who stated that CNA #2 who was assigned to care for Resident #32 should have made rounds that morning when she had arrived at the unit and checked the residents to see if any residents were incontinent and needed to be changed right away. UM/LPN #2 could not speak to why Resident #32 was wet including the resident's bed linens. UM/LPN #2 stated it was import to assure that the residents were clean and dry to protect the resident's skin and to keep residents comfortable. A review of the CNA Assignment sheet for 6/18/24, revealed that for the resident census of 50, there were five assigned CNAs. CNA #2 had eleven assigned residents to care for. On 6/25/24 at 10:13 AM, the surveyor interviewed the Staffing Coordinator in the presence of the Licensed Nursing Home Administrator (LNHA), who stated she scheduled nursing staff in accordance with State regulation which required one CNA to every eight residents for the morning shift; one CNA for every ten residents for the evening shift; and one CNA to every fourteen residents for the overnight shift. The Staffing Coordinator stated it was very hard to find staff; that the facility did not always meet the required ratios. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/25/24 at 1:27 PM, the surveyor in the presence of the DON, Regional Nurse, and survey team, asked the LNHA what their role was. The LNHA stated their role was to oversee operations for the facility, all departments and department heads to ensure residents received the services, were safe, and needs were met. 4. On 6/19/24 at 1:27 PM, the surveyor requested from the LNHA and DON the Consultant Pharmacist's (CP) recommendations for Resident #34, #60, #61, and #80) from March 2024 until present. A review of the CP's recommendations revealed that recommendations made in March 2024, were acted on after surveyor inquiry. On 6/20/24 at 9:36 AM, the surveyor interviewed the DON who stated that the CP reports were sent to the facility through email by the CP, and the CP's recommendations were to be completed by the unit managers. The DON stated that an appropriate time for the CP's recommendations to be completed was within seven days of receiving. The DON could not explain why the recommendations provided from the CP from March 2024, April 2024 and May 2024 were not completed until 6/19/24 after surveyor inquiry. On 6/20/24 at 10:16 AM, the surveyor interviewed UM/LPN #1 who stated that the CP report recommendations were usually completed by the unit manager, but could be assigned to the nurse on the unit or divided amongst the nursing staff to complete. UM/LPN #1 stated that an appropriate time to complete the CP's recommendation report was within one week. She continued to add that the unit managers usually received an email of the recommendations, but since switching over to the new electronic medical records (EMR), which was switched on 6/11/24, the DON received the recommendations. UM/LPN #1 revealed that the CP recommendations from March 2024, April 2024 and May 2024 were not given to the unit managers to complete until yesterday (6/19/24). On 6/20/24 at 12:24 PM, the surveyor interviewed the facility's CP who stated that she had been at the facility since March 2024, and it was important that the facility acted upon the pharmacy recommendations as soon as possible (ASAP) so that if there was a medication safety concern, it could be taking care of immediately. The CP stated that the facility needed more education because the new pharmacy consultant company was new to the facility and the staff was on a learning curve. On 6/25/24 at 1:27 PM, the surveyor in the presence of the DON, Regional Nurse, and survey team, asked the LNHA what their role was. The LNHA stated their role was to oversee operations for the facility, all departments and department heads to ensure residents received the services, were safe, and needs were met. 5. On 6/17/24 at 1:00 PM, the surveyor requested from the LNHA a copy of investigations for reportable events to the New Jersey Department of Health (NJDOH) or any investigations that included injury of unknown origin or allegation of abuse and neglect for July and August 2023. The surveyor reviewed an investigation for the closed medical record for Resident #254. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Belle Care Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 439 Bellevue Avenue Trenton, NJ 08618	

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Incident Report dated 8/14/23 at 8:30 AM, revealed that the ADON was called to Resident #254's room to assess the resident who had blue discoloration on both ears, a three centimeter by three centimeter (3 cm x 3 cm) abrasion to right knee; discoloration on right side of face and mid arm. When staff attempted to turn the resident over, the resident screamed in pain; the physician was made aware and a new order was put in place to send to the emergency room (ER) for evaluation. The ER report indicated the resident sustained a lower back fracture. The resident's medical record revealed prior to the injury of unknown origin, they were on one to one (1:1) monitoring every shift. The incident report did not include how a resident on 1:1 monitoring sustained bruising to both ears and a lower back fracture through an unwitnessed fall. On 6/20/24 at 1:24 PM, the survey team met with the LNHA and the DON, and the surveyor requested additional information on how a resident who was on 1:1 monitoring had an unwitnessed fall that resulted in two bruised ears and a fractured back. At that time, the LNHA acknowledged that the investigation should include how the resident on a 1:1 had an unwitnessed fall. On 6/25/24 at 1:27 PM, the surveyor in the presence of the DON, Regional Nurse, and survey team, asked the LNHA what their role was. The LNHA stated their role was to oversee operations for the facility, all departments and department heads to ensure residents received the services, were safe, and needs were met. On 6/26/24 at 10:36 AM, the survey team met with the LNHA, DON, and ADON to discuss their concerns. The LNHA stated an investigation should have included an assessment of the resident, interviews of possible witnesses and resident, psychology if needed, psychosocial if needed with a social worker, summary, conclusion and interventions put in place so will not happen again, and individualized comprehensive care plan (ICCP) was updated. 6. During entrance conference on 6/17/24 at 10:00 AM, the surveyor requested from the LNHA and the DON a copy of the facility's assessment. During initial tour on 6/17/24 at 10:29 AM, the surveyor observed Resident #26 observed in bed asleep. The surveyor observed that both the resident and their unsampled roommate were both incarcerated with four Corrections Officers (CO) present in the room. On 6/24/24 at 1:03 PM, the surveyor asked the LNHA and Maintenance Director if the facility had any special populations, and the LNHA confirmed the facility had registered sex offenders and inmates from the [Local] County Jail. A review of the facility provided Facility Staffing & Resource Assessment Completion Based indicated persons completing assessment included the LNHA, DON, and Medical Director updated 9/17/23 and reviewed with the Quality Assurance and Performance Improvement (QAPI) committee and signed by the LNHA on 4/30/24, did not include registered sex offenders or incarcerated residents as part of the facility's population. On 6/25/24 at 1:27 PM, the surveyor in the presence of the DON, Regional Nurse, and survey team, asked the LNHA what their role was. The LNHA stated their role was to oversee operations for the facility, all departments and department heads to ensure residents received the services, were safe, and needs were met. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/26/24 at 10:36 AM, the LNHA in the presence of the DON, ADON, and survey team acknowledged the registered sex offenders and inmates were not included in the facility assessment. 7. On 6/20/24 at 12:57 PM, the survey team met with the LNHA and DON to discuss their concerns which included accuracy of the Minimum Data Set (MDS) assessments; medication storage; acting on Consultant Pharmacy (CP) reports; and antibiotic stewardship program. On 6/24/24 at 1:03 PM, the surveyor asked the LNHA and Maintenance Director if the facility had any special populations, and the LNHA confirmed the facility had registered sex offenders and inmates from the [Local] County Jail. A review of the facility provided Facility Staffing & Resource Assessment Completion Based indicated persons completing assessment included the LNHA, DON, and Medical Director updated 9/17/23 and reviewed with the QAPI committee on 4/30/24, did not include registered sex offenders or incarcerated residents as part of the facility's population. On 6/25/24 at 1:22 PM, the survey team met with the LNHA, DON, and Regional Nurse to discuss additional concerns which included the facility's assessment did not include registered sex offenders or inmates in their special population. On 6/25/24 at 1:27 PM, the surveyor in the presence of the DON, Regional Nurse, and survey team, asked the LNHA what their role was. The LNHA stated their role was to oversee operations for the facility, all departments and department heads to ensure residents received the services, were safe, and needs were met. A review of the Centers for Medicare & Medicaid Services (CMS) 2567 statement of deficiencies from the facility's last standard survey included the facility was cited for the following concerns: MDS assessments, medication storage, acting on CP reports, antibiotic stewardship program, facility assessment to include registered sex offenders and inmates, and the facility's QAPI program. On 6/26/24 at 11:52 AM, the survey team met with the LNHA, DON, and ADON to discuss the facility's QAPI program which all three staff members were part of. When asked where the facility obtained their concerns for their QAPI program, the LNHA stated the facility utilized the CMS 2567 statement of deficiencies from previous surveys. The survey team informed the facility that there were repeated concerns from the last standard survey which included MDS assessments, medication storage, acting on CP reports, antibiotic stewardship program, facility assessment, and QAPI, and asked what the facility implemented to ensure sustainability. The LNHA acknowledged that even though she started at the facility in April 2024, she was present for the April quarterly QAPI meeting as well as reviewed and signed the facility assessment and reviewed the CMS 2567 from last standard survey. At that time the DON stated she was aware of the facility's previous deficiencies and that facility educated staff and completed reports. NJAC 8:39-9.2(a); 9.3(a); 27.1(a)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 38080 Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the facility-wide assessment identified the required services and procedures necessary to protect the health, safety, and welfare of all residents prior to admission of registered sex offenders and residents admitted from the correctional facility. This deficient practice was previously identified and cited during the facility's last standard survey on 10/20/22, and was evidenced by the following: Refer F865 During entrance conference on 6/17/24 at 10:00 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) a copy of the facility's assessment. During initial tour on 6/17/24 at 10:29 AM, the surveyor observed Resident #26 observed in bed asleep. The surveyor observed that both the resident and their unsampled roommate were both incarcerated with four Corrections Officers (CO) present in the room. On 6/24/24 at 1:03 PM, the surveyor asked the LNHA and Maintenance Director if the facility had any special populations, and the LNHA confirmed the facility had registered sex offenders and inmates from the [Local] County Jail. A review of the facility provided Facility Staffing & Resource Assessment Completion Based indicated persons completing assessment included the LNHA, DON, and Medical Director updated 9/17/23 and reviewed with the Quality Assurance and Performance Improvement (QAPI) committee on 4/30/24, did not include registered sex offenders or incarcerated residents as part of the facility's population. On 6/26/24 at 10:36 AM, the LNHA in the presence of the DON, Assistant Director of Nursing (ADON), and survey team acknowledged the registered sex offenders and inmates were not included in the facility assessment. During an interview regarding the facility's QAPI program on 6/26/24 at 11:52 AM, the LNHA acknowledged the facility was previously cited for this during the facility's last annual survey. On 6/26/24 at 12:00 PM, the LNHA informed the survey team that the facility did not have a main contract with the prison, but the facility had individual contracts for the two residents who were inmates currently residing at the facility. NJAC 8:39-5.1(a)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 38080 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure that a.) their Quality Assurance and Performance Improvement (QAPI) Program was being implemented to ensure sustainability with previously cited deficiencies and b.) sources of quantitative data was being analyzed to identify quality deficiencies and evaluate program effectiveness. The facility was cited during last standard survey on 10/20/22, and was evidenced by the following: Refer F641, F756, F761, F838, and F881 During entrance conference on 6/17/24 at 10:00 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) a copy of the facility's QAPI program plan and the last three quarterly sign-in sheets. On 6/18/24 at 11:52 AM, the surveyor requested from the LNHA a copy of the facility's QAPI program plan and last three quarterly sign-in sheets. On 6/19/24 at 9:00 AM, the surveyor received a copy of the last three quarterly sign-in sheets for the facility's QAPI program, but no policy was provided. On 6/20/24 at 12:57 PM, the survey team met with the LNHA and DON to discuss their concerns which included accuracy of the Minimum Data Set (MDS) assessments; medication storage; acting on Consultant Pharmacy (CP) reports; and antibiotic stewardship program. On 6/24/24 at 1:03 PM, the surveyor asked the LNHA and Maintenance Director if the facility had any special populations, and the LNHA confirmed the facility had registered sex offenders and inmates from the [Local] County Jail. A review of the facility provided Facility Staffing & Resource Assessment Completion Based indicated persons completing assessment included the LNHA, DON, and Medical Director updated 9/17/23 and reviewed with the QAPI committee on 4/30/24, did not include registered sex offenders or incarcerated residents as part of the facility's population. On 6/25/24 at 1:22 PM, the survey team met with the LNHA, DON, and Regional Nurse to discuss additional concerns which included the facility's assessment did not include registered sex offenders or inmates in their special population. A review of the Centers for Medicare & Medicaid Services (CMS) 2567 statement of deficiencies from the facility's last standard survey included the facility was cited for the following concerns: MDS assessments, medication storage, acting on CP reports, antibiotic stewardship program, facility assessment to include registered sex offenders and inmates, and the facility's QAPI program. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/26/24 at 11:52 AM, the survey team met with the LNHA, DON, and Assistant Director of Nursing (ADON) to discuss the facility's QAPI program which all three staff members were part of. When asked where the facility obtained their concerns for their QAPI program, the LNHA stated the facility utilized the CMS 2567 statement of deficiencies from previous surveys. The survey team informed the facility that there were repeated concerns from the last standard survey which included MDS assessments, medication storage, acting on CP reports, antibiotic stewardship program, facility assessment, and QAPI, and asked what the facility implemented to ensure sustainability. The LNHA acknowledged that even though she started at the facility in April 2024, she was present for the April quarterly QAPI meeting as well as reviewed and signed the facility assessment and reviewed the CMS 2567 from last standard survey. At that time the DON stated she was aware of the facility's previous deficiencies and that facility educated staff and completed reports. No additional information was provided. A review of the facility provided Administrator job descriptions included the Administrator is responsible for planning and is accountable for all activities and departments at [name redacted] subject to rules and regulations promulgated by government agencies to ensure proper health care services to residents. The Administrator administers, directs, and coordinates all activities of the facility to assure that the highest degree of care is constantly provided to the residents . A review of the facility provided Senior Director of Nursing Services job descriptions included in addition to the standard responsibilities of Director of Nursing, Senior Director of Nursing is responsible for providing leadership, training and expert guidance. Individuals selected for this position and must be knowledgeable in all aspects of long term care nursing and have demonstrated ability in managing a nursing department . Performs Related Duties: 1. in the absence of the Administrator and/or licensed Assistant Administrator, the DON is responsible carrying out the administrative duties of the nursing facility . NJAC 8:39-33.1(a)(e); 33.2 (a)(b)(c)(d)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

49094

Based on observation, interview, review of pertinent facility documents, it was determined that the facility failed to: a) change respiratory equipment tubing in a manner to prevent the spread of infection for 1 of 1 resident reviewed for respiratory care (Resident #80); b.) ensure that infection control standards were followed during medication pass for 1 of 2 nurses observed during medication administration; and c.) ensure staff maintained appropriate nail length to prevent the spread of infection for 1 of 2 unit managers. This deficient practice was identified on 2 of 2 nursing units, and was evidenced by the following:

1. During the initial tour of the Second Floor nursing unit on 6/17/24 at 10:52 AM, the surveyor observed Resident #80 lying in bed. Resident #80 was receiving humidified oxygen at 3 liters per minute (lpm) via nasal cannula (tubing that delivered oxygen through the nose). The surveyor observed the nasal cannula tubing with a piece of clear tape attached to the tubing dated 6/5/24.

The surveyor reviewed the medical record for Resident #80.

A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to facility with diagnoses which included chronic obstructive pulmonary disease (COPD) (refers to a group of diseases that cause airflow blockage and breathing-related problems), morbid obesity (having too much body fat, which increases the risk of health problems), and anemia (low levels of healthy red blood cells to carry oxygen throughout your body).

A review of the most recent Minimum Data Set (MDS), an assessment tool dated 4/25/24, revealed the resident had a brief interview for mental status (BIMS) score of 15 out of 15, which indicated a fully intact cognition.

A review of the June 2024 Treatment Administration Record (TAR) included a physician's order (PO) dated 6/12/24, to change oxygen cannula/tubing once weekly on Wednesday during the night shift and as needed.

On 6/19/24 at 10:18 AM, the surveyor observed Resident #80 lying in bed awake and alert. Resident #80 was receiving humidified oxygen at 3 lpm via nasal cannula. The surveyor observed the nasal cannula tubing with a piece of clear tape attached to the tubing dated 6/5/24. Resident #80 said that they change my oxygen tubing when I ask the nurse, and the last time it was done was about two weeks ago.

On 6/20/24 at 11:48 AM, the surveyor interviewed Licensed Practical Nurse (LPN #1) regarding how often oxygen tubing was changed, and LPN #1 responded it was changed weekly by the overnight nurse. LPN #1 confirmed the resident should not be using nasal tubing that was more than seven days old.

On 6/20/24 at 12:20 PM, the surveyor interviewed the Director of Nursing (DON) who confirmed oxygen tubing was changed weekly on the 11:00 PM to 7:00 AM shift by the nurse. The DON stated the nurse dated when they changed the tubing. The DON acknowledged nasal tubing should not be used past seven days because it was an infection control issue.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility had no Infection Preventionist. A review of the facility's Cleaning Respiratory Equipment policy dated revised May 2022, included Procedure: 1. Supplies: Replace masks and/or cannula used by an individual resident within seven (7) days and as needed (PRN) when obviously contaminated . 34033 2. On 6/18/24 at 8:59 AM, during the morning medication administration pass, the surveyor, observed the Registered Nurse (RN) preparing eight (8) medications for Resident #5 which included Cosopt (an eye drop medication used for glaucoma) eye drops. The RN stated that she did not have any tissues on the medication cart to use when administering the Cosopt eye drops. The surveyor observed the RN, with gloved hands, go into the resident's bathroom and removed toilet paper from the roll that was hanging in the bathroom. The RN then folded the toilet paper into a small wad, and used the toilet paper to dab the right eye after administering one drop of the Cosopt and then turned the toilet paper wad over and used the other side to dab the left eye after administering one drop of Cosopt into the left eye. On 6/18/24 at 9:13 AM, the surveyor interviewed the RN who stated that she felt the toilet tissue was clean. The RN also stated that she was an agency nurse, and this was not her usual medication cart and that it was difficult to know what was stocked in the cart. On 6/19/24 at 1:13 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON. The DON confirmed that toilet paper from the bathroom should not have been used while administering eye drops, it was not sanitary. The DON stated that there were boxes of tissues provided for the medication carts. The facility had no Infection Preventionist. A review of the facility's Medication Administration policy dated 12/23/23, included .Prior to preparing and administering medications, follow the facility's infection control policies (for example, handwashing) . 38080 3. On 6/17/24 at 9:56 AM, the surveyor observed the Unit Manager/Licensed Practical Nurse (UM/LPN) at a medication cart. The UM/LPN stated she was administering medication to residents. The surveyor observed her nails to be manicured and long in length. On 6/25/24 at 11:30 AM, the surveyor observed The UM/LPN at the nurse's station with long manicured acrylic nails that were over an inch in length and curled. The surveyor commented to the UM/LPN that their nails were long, and the UM/LPN hid their nails and replied not to look at them. The surveyor asked the UM/LPN if they provided resident care, and the UM/LPN replied no. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/24 at 1:30 PM, the surveyor interviewed the DON and LNHA, and the DON stated if there was a staffing issue, the unit manager should assist with resident care. The DON acknowledged administering residents' medications was considered resident care. When asked if they were aware of the UM/LPN's nail length, both the LNHA and DON acknowledged that the UM/LPN's nail length was not appropriate. The DON stated they were too long which could result in bacterial growth underneath as well as resident care issues. The facility had no Infection Preventionist. A review of the facility provided Dress Code which required an employee signature and date, included the length of nails should be reasonable so as not to interfere with resident care or time clock . NJAC 8:39-19.4(a)(k)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 38080 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) implement a facility-wide system to monitor antibiotic use specifically according to the facility's antibiotic stewardship program and b.) monitor antibiotic use and conduct surveillance from January 2024 through June 2024. This deficient practice was cited during the facility's last standard survey on 10/20/22, and was evidenced by the following: Refer F865 According to the U.S. CDC Core Elements of Antibiotic Stewardship for Nursing Home, page last reviewed June 11, 2020, included, Tracking and Reporting Antibiotic Use and Outcomes Nursing homes monitor both antibiotic use practices and outcomes related to antibiotics in order to guide practice changes and track the impact of new interventions. Data on adherence to antibiotic prescribing policies and antibiotic use are shared with clinicians and nurses to maintain awareness about the progress being made in antibiotic stewardship. Process measures: Tracking how and why antibiotics are prescribed Perform reviews on resident medical records for new antibiotic starts to determine whether the clinical assessment, prescription documentation, and antibiotic selection were in accordance with facility antibiotic use policies and practices. When conducted over time, monitoring process measures can assess whether antibiotic prescribing policies are being followed by staff and clinicians. A review of the facility's Antibiotic Stewardship policy dated reviewed January 2022, included the [Infection Preventionist (IP)] or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics .All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: resident name and medical record number; unit and room number; date and symptoms appeared; name of antibiotic; start date of antibiotic; pathogen identified; site of infection; date of culture; stop date; total days of therapy; outcome; and adverse events. During entrance conference on 6/17/24 at 10:00 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) who the facility's Infection Preventionist (IP) was, and the DON stated the facility's previous IP left about two or three months ago and the position was vacant. The DON stated herself, the Assistant Director of Nursing (ADON), and the two unit managers reviewed immunizations, antibiotic stewardship, and infection control issues. At that time the surveyor requested a copy of the infection control certifications as well as the date the IP stopped working. On 6/18/24 at 11:42 AM, the surveyor requested from the LNHA a copy of the infection control certifications and the last date the IP worked. On 6/19/24 at 12:55 PM, the surveyor requested from the LNHA a copy of the infection control certifications and the last date the IP worked as well as the antibiotic stewardship tracking and surveillance. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/19/24 at 1:36 PM, the surveyor interviewed the DON who stated she did not have a certification in infection control; but she reviewed infection control with the ADON who also was not certified. The DON stated only the Unit Manager/Licensed Practical Nurse (UM/LPN) had an infection control certification. The DON stated the unit managers provided the antibiotic stewardship information to the ADON who reviewed, summarized, and completed the monthly report, and the ADON in-services staff on infection control. On 6/20/24 at 12:36 PM, the ADON provided the surveyor with a copy of the facility's Monthly Antibiotic Summary since January 2024. A review of the summary revealed the following: In January 2024, four residents received antibiotics, and three residents had a blank for the diagnostic section (X-ray and laboratory). In February 2024, six residents received antibiotics, and all six had a blank for the diagnostic section. Resident #40 had no documented symptoms. In March 2024, six residents received antibiotics, and all six had a blank for the diagnostic section. Resident #44 and Resident #98 both were not indicated if they met the criteria for an antibiotic. For April 2024, four residents received antibiotics with no residents having documented symptoms; two had diagnostic test documented; none had the origin documented; and no one had documented if the criteria was met. For May 2024, eleven residents received antibiotics with only two residents had documented symptoms; no one had diagnostic tests documented; none had the origin documented; and no one had documented if the criteria was met. For June 2024, eight residents received antibiotics with Resident #197 with no documented symptoms; and no one had documented diagnostic testing, origin, or criteria met. On 6/20/24 at 12:36 PM, the surveyor interviewed the ADON who stated the facility had no IP since April of 2024, everyone was pitching in with infection control. When asked why the summaries were not completed, the ADON stated she had just completed May's antibiotic stewardship review yesterday. On 6/20/24 at 12:57 PM, the surveyor informed the LNHA and DON about the missing documentation for the antibiotic stewardship. The DON stated there was a log on the medication cart with the antibiotic that was being tracked. No additional information was provided. NJAC 8:39-19.1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Belle Care Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 439 Bellevue Avenue Trenton, NJ 08618	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 38080 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to hire a designated Infection Preventionist (IP) who worked at least part-time and had completed specialized training in infection control and prevention. The deficient practice was identified and evidenced by the following: Refer F880; F881; and F883 During entrance conference on 6/17/24 at 10:00 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) who the facility's Infection Preventionist (IP) was, and the DON stated the facility's previous IP left about two or three months ago and the position was vacant. The DON stated herself, the Assistant Director of Nursing (ADON), and the two unit managers reviewed immunizations, antibiotic stewardship, and infection control issues. At that time the surveyor requested a copy of the infection control certifications as well as the date the IP stopped working. On 6/18/24 at 11:42 AM, the surveyor requested from the LNHA a copy of the infection control certifications and the last date the IP worked. On 6/19/24 at 12:55 PM, the surveyor requested from the LNHA a copy of the infection control certifications and the last date the IP worked. On 6/19/24 at 1:36 PM, the surveyor interviewed the DON who stated she did not have a certification in infection control; but she reviewed infection control with the Assistant Director of Nursing (ADON) who also was not certified. The DON stated only the Unit Manager/Licensed Practical Nurse (UM/LPN) had an infection control certification. The DON stated the unit managers provided the antibiotic stewardship information to the ADON who reviewed, summarized, and completed the monthly report, and the ADON in-serviced staff on infection control. On 6/20/24 at 12:36 PM, the surveyor interviewed the ADON who stated the facility had no IP since April of 2024, everyone was pitching in with infection control. The ADON stated she had just completed May's antibiotic stewardship review yesterday. On 6/25/24 at 10:58 AM, the surveyor re-interviewed the ADON who confirmed she had no infection control certification, and she was responsible for providing staff with infection control training. On 6/25/24 at 1:30 PM, the surveyor informed the LNHA and DON of the concern with infection control. The LNHA stated the previous IP's last day of work was 5/3/24. No additional information was provided. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's undated Infection Prevention and Control Program policy included the infection prevention and control program is coordinated and overseen by an infection prevention specialist (infection preventionist). The qualifications and job responsibilities of the Infection Preventionist are outlined in the Infection Preventionist Job Description . NJAC 8:39-19.1(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49094 Based on interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to implement their policy to a.) ensure all eligible residents were educated on the benefits and potential side effects of the pneumococcal immunization and b.) document in the medical record the residents' education and refusal of the pneumococcal immunization. The deficient practice was identified for 2 of 8 residents reviewed for immunizations (Resident #76 and Resident #87), and was evidenced by the following: 1. According to the Admission Record, Resident #87 was admitted to the facility with diagnoses including but not limited to diabetes mellitus (a disease of inadequate control of blood levels of glucose), hypertension (high blood pressure), heart failure (heart muscle does not pump blood as well as it should), and stroke (damage to the brain from interruption of its blood supply). A review of the most recent Minimum Data Set (MDS), an assessment tool dated 3/18/24, reflected the resident had a brief interview for mental status score of 15 of out of 15, indicating a fully intact cognition. A review of Section O0300 indicated Resident #87's pneumococcal vaccine (immunization) was not up to date; that the resident was offered and declined. A review of Resident #87's Immunization Record revealed no pneumococcal vaccine was administered, but the resident was administered influenza vaccine on 3/11/24. A review of Resident #87's Progress Notes did not include documentation that the resident was educated, offered, and declined the vaccination. On 6/20/24, the surveyor requested the Pneumococcal Immunization Informed Consent declination form from the Director of Nursing (DON). On 6/24/24, a review of a Pneumococcal Immunization Informed Consent, revealed that Resident #87 was offered the pneumonia vaccine on 6/18/24 and declined. There was no documentation that the resident was offered or that the resident was offered the pneumococcal vaccine prior to survey. On 6/24/24 at 10:02 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated upon admission, the nurse reviewed the resident's vaccination status. The ADON stated if there was no documented immunizations received, the nurse offered the immunization and had the resident signed the consent form or declined the immunization on the same form. The ADON stated the resident was offered the pneumococcal vaccine on 6/18/24, but declined. The ADON confirmed the facility did not have the resident's declination form from admission. On 6/26/24 at 10:35 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), ADON, and survey team stated, the resident was offered on admissions, but the facility could not provide documentation. 2. According to the Admission Record, Resident #76 was admitted to the facility with diagnoses included hypertension (high blood pressure), stroke (damage to the brain from interruption of its blood supply), and end stage renal disease (kidneys can no longer function on their own). (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the most recent MDS dated [DATE], reflected the resident had a BIMS score of 13 out of 15, which indicated a fully intact cognition. A review of Section O0300 indicated Resident #76's pneumococcal vaccine was not up to date; that the resident was offered and declined. A review of Resident #76's Immunization Record, revealed no pneumococcal vaccine administered, but the resident was administered influenza vaccine on 9/22/23. A review of Resident #76's Progress Notes did not include documentation that the resident was educated, offered, and declined the pneumococcal vaccine. On 6/20/24, the surveyor requested the Pneumococcal Immunization Informed Consent declination form from the DON. On 6/24/24, a review of a Pneumococcal Immunization Informed Consent, revealed that Resident #76 was offered the pneumonia vaccine on 6/23/24, and declined. There was no documentation that the resident was educated or that the resident was offered the pneumococcal vaccine prior to surveyor inquiry. On 6/24/24 at 10:02 AM, the surveyor interviewed the ADON who stated upon admission, the nurse reviewed the resident's vaccination status. The ADON stated if there was no documented immunizations received, the nurse offered the immunization and had the resident signed the consent form or declined the immunization on the same form. The ADON stated the resident was offered the pneumococcal vaccine on 6/23/24, but declined. The ADON confirmed the facility did not have the resident's declination form from admission. On 6/26/24 at 10:35 AM, the DON in the presence of the LNHA, ADON, and survey team stated, the resident was offered on admissions, but the facility could not provide documentation. A review of the facility's undated Pneumococcal Vaccine policy included all residents will be offered pneumococcal vaccines to aide in preventing pneumonia/pneumococcal infections. Prior to admissions residents will be assessed for eligibility to receive pneumococcal series, and when indicated, will be offered the vaccine series within thirty days of admission .before receiving the pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccines[.]provisions of such education shall be documented in the resident's medical record .residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of refusal of the pneumococcal vaccination . NJAC 8:39-19.4(i)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45209 Complaint NJ #159451; 159539; 159783; 162168 Based on observation, interview, and review of other facility documentation it was determined that the facility failed to maintain resident environment, equipment, and living areas in a safe, sanitary, and homelike manner. This deficient practice was identified for 2 of 2 nursing units (First and Second Floor) and was evidenced by the following: On 6/19/24 at 9:09 AM, the surveyor observed in the hallway by Resident room [ROOM NUMBER] a wheelchair with brown matter that resembled fecal matter, smeared across the seat cushion and down the leg of the wheelchair onto the wheels. On 6/20/24 at 10:52 AM, the surveyor observed on the Second Floor nursing unit a strong urine odor while approaching Resident room [ROOM NUMBER]. The surveyor entered the room to discover the floor by Bed B was wet and sticky. In addition, puddles of wetness was observed on the bed. On 6/20/24 at 11:41 AM, the surveyor requested that Registered Nurse (RN #1) walk with them to Resident room [ROOM NUMBER]. While approaching the room, RN #1 acknowledged the strong urine odor, and confirmed that they were aware of the room's condition. On 6/20/24 at 11:55 AM, the Unit Manager/Licensed Practical Nurse (UM/LPN #1) confirmed the strong smell of urine and acknowledged that Resident room [ROOM NUMBER] should not be in that condition. On 6/25/24 at 9:43 AM, the surveyor interviewed the Director of Nursing (DON) who acknowledged that Resident room [ROOM NUMBER] should have been cleaned in a timely fashion; that residents should receive quality of care and living environments. On 6/26/24 at 10:35 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the DON, Assistant Director of Nursing (ADON), and survey team acknowledged that the wheelchair and resident room, which resulted in the urine smell in the hallway, were not acceptable. A review of the facility's undated Quality of Life- Homelike Environment policy included .2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order .e. Pleasant, neutral scents . A review of the facility's Cleaning and Disinfecting Wheelchairs, [Reclining Chairs, Bedside Commode, & Privacy Curtains policy dated last reviewed March 2024, included . 1. Ensure that wheelchairs and [reclining chairs] are kept clean and in good repair [.] 4. Designate an area for cleaning wheelchairs, [reclining chairs], and bedside commode. If necessary, use a power spray and clean heavily soiled wheelchairs outside . NJAC 8:39-4.1 (a), 11