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	01/05/2026

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview, review of Nursing Staffing Report sheets and facility provided documents, it was determined that the facility failed to ensure a Registered Nurse (RN) worked 7 days a week for at least 8 consecutive hours a day for 10 of 42 days reviewed 09/21/2025 through 12/27/2025. The deficient practice was evidenced by the following: A review of the Nurse Staffing Reports completed by the facility for the week of 09/21/2025 through 12/27/2025, revealed the facility had no RN coverage for all shifts on 10/03/2025, 11/24/2025, 12/16/2025, 12/17/2025, 12/18/2025, 12/22/2025, 12/24/2025, 12/25/2025 and 12/26/2025. During an interview on 01/02/2026 at 11:50 AM with the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA), the DON stated that if a licensed nurse is unavailable, she will cover, and if an RN cannot work 8 consecutive hours, another RN, regional staff, or agency staff (last used 08/2025) will be contacted. The LNHA noted that there have been instances of no RNs documented in the nursing reports. A review of a facility policy dated 10/15/2025 titled Staffing, revealed that, Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. Direct care staffing information per day (including agency and contract staff) is submitted to the CMS Payroll-Based Journal system on the schedule specified by CMS, but no less than once a quarter. Inquiries or concerns regarding our facility's staffing should be directed to the administrator or his/her designee. NJAC 8:39-25.2(h)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of facility documents, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following:On 12/29/2025 from 09:30 AM until 09:55 AM during the initial tour of the kitchen, the surveyor, in the presence of the Director of Dining (DOD) observed the following:1. In the walk-in refrigerator, a covered pie had no label and was not dated. The DOD acknowledged it should be dated and the item was removed. 2. In the walk-in freezer, bagged frozen waffles, bagged frozen fish, frozen hamburger patties and an opened package of bacon had no label and were not dated. The DOD stated the waffles, fish, hamburger patties, and the bacon should be dated. The items were removed.3.In the refrigerator, an opened wrapped package of shredded cheese not dated. The DOD stated that it should be dated. 4. In the refrigerator, a single halved tomato wrapped in clear plastic wrap with no label and not dated. The DOD stated the item should be dated. 5. In the refrigerator, a container of honey mustard had a use by date of 11/20/2025. The DOD removed the item from the refrigerator and disposed of it. The surveyor reviewed the undated facility provided policy titled, Dating and Labeling which reflected: all food items will be labeled with a received date upon acceptance of delivery. Follow the Labeling and Dating System Protocol for all dating other than the received date of all products. Use the [Trade Name] system, address label, or black marker with legible writing to date and label products in accordance with the Labeling and Dating System Protocol. Discard all foods that expire immediately. The surveyor reviewed the undated facility-provided policy titled, Labeling and Dating System Protocol, that reflected all fresh and frozen foods must be dated with the date it was received into the kitchen, unless it has a purveyor shipping label on it. Follow manufactures expiration date on all un-opened or opened product. The policy indicated that if there is no printed manufacturers date on the product to follow the provided dating time frames based on the food item. NJAC 8:39-17.2(g)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview and review of facility documentation, it was determined that the facility failed to provide immediate access to records and requested information necessary to conduct the survey.The deficient practice was evidenced by the following: On 12/29/2025 at 9:00 AM, the survey team entered the facility and was greeted by the Assistant Director of Nursing (ADON) who was instructed by the Survey Team Coordinator to provide an alphabetical roster of residents and a roster by room number, the Facility Matrix for admissions in the last 30 days, and a list of residents who smoke.On the same date at 9:56 AM, no facility staff member brought any of the requested documents except an alphabetical list of the residents. On 12/29/2025 at 10:01 AM, the Survey Team Coordinator spoke with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) via the ADON's cellular phone. At that time, the DON said she was on vacation last week and was not expecting a survey.On 12/29/2025 at 10:36 AM, the entrance conference began with the arrival of the DON and LNHA. During the entrance conference, the Survey Team Coordinator requested the Infection Preventionist's (IP) primary professional training and specialized training documentation, the Infection Prevention and Control Program (IPCP) standards, policies and procedures, the surveillance plan, the Antibiotic Stewardship program, and the immunization policies.A review of the Facility Entrance Conference request list revealed that the IP training documentation was required to be provided within one hour of entrance and the IPCP policies were required within four hours of entrance.During the entrance conference, the LNHA was also informed that the survey team required all employee personnel and medical files for staff hired or terminated since the last recertification survey on 06/26/2024. The LNHA told the Survey Team Coordinator that the facility had the files.On 12/29/2025 at 1:12 PM, the Survey Team Coordinator requested the LNHA to complete the AAS-11 (Daily Nursing Staff Report used to track actual hours worked by shift) and AAS-12 (Facility Census and Care Evaluation used to track resident acuity and specialized clinical needs.) for the facility staffing and return them via email by 8:00 AM on 12/30/2025.On 12/30/2025 at 12:15 PM, the Survey Team Coordinator received the IP training documentation and the IPCP policies, approximately 25 hours and 21 hours after the respective deadlines.On 12/30/2025 at 1:10 PM, the facility provided the human resource portion of the employee files but did not provide the medical files. At that time, the Human Resource Manger told the survey team that the IP holds the medical records of employees.On 12/31/2025 at 10:35 AM, the survey team received the AAS-11 and AAS-12 forms.A review of the AAS-11 and AAS-12 forms completed by the LNHA, revealed inconsistent numbers and blank sections on the forms. The Survey Team Coordinator returned the forms to the LNHA for correction.On 12/31/2025 at 12:36 PM, the LNHA returned the forms via email, which were reviewed and found to have additional errors.On 12/31/2025 at 12:43 PM, the LNHA returned the forms with corrections that were again found to be missing needed data.On 1/02/2026 at 10:13 AM, the LNHA provided the forms again which again, were discovered to contain data-entry errors.On 1/02/2026 at 12:26 PM, the survey team met with the LNHA to identify continued findings of inconsistent data entry. The LNHA appeared to correct the data on her computer in the presence of the surveyors and emailed the final forms at 1:12 PM which were determined to be inaccurate again.On 1/05/2026 at 10:13 AM, the LNHA sent the forms to the survey team for the last time for Department of Health review.A review of the facility provided Job Description document titled, Position Title: Administrator' revealed, The Administrator is responsible for planning and is accountable for all activities and departments of [Facility Name] 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 assure that the highest degree of quality of care is consistently provided to the residents.A review of the document also revealed that, 3. Meets with licensing authorities as required and accompanies them throughout and survey of the facility.N.J.A.C. 8:39-9.2(a)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and review of facility documents, it was determined that the facility failed to ensure that staffing data submitted to the Centers for Medicare & Medicaid Services (CMS) through the Payroll-Based Journal (PBJ) system was accurate and complete for 1 of 2 PBJ Staffing Data Reports reviewed under the Sufficient and Competent Nurse Staff Task.The deficient practice was evidenced by the following:The facility reported on the AAS-11 (Daily Nursing Staff Report) that no Registered Nurse (RN) services were available on 10/03/2025, 11/24/2025, 12/16/2025, 12/17/2025, 12/18/2025, 12/22/2025, 12/25/2025, and 12/26/2025.A review of the PBJ Staffing Data Report (CASPER Report 1705D) for Fiscal Year Quarter 1, 2025 (October 1, 2025, through December 31, 2025) revealed that the facility had not triggered No RN Hours for the dates identified on the AAS-11.On 1/02/2026 at 11:45 AM, during an interview with the surveyor, the Human Resource Manager (HRM) confirmed there were 24-hour periods without a registered nurse as indicated on the state staffing form (AAS-11). When the surveyor asked if she reported those shifts through PBJ reporting, the HRM replied, Yes.The Licensed Nursing Home Administration (LNHA) provided the surveyor two copies of the CMS Submission Report PBJ Final File Validation Report dated 8/14/2025 and 11/14/2025.A review of the validation reports revealed that the reports both state at the bottom, NOTE: This validation Report only validates whether or not the data submitted was received successfully; however, it does not reflect the accuracy or completeness of a facility's data.A review of the facility-provided policy titled, Payroll Base Journal (PBJ)-Staffing Data Submission revealed, To establish a standardized process for the accurate collection, validation, and timely submission of staffing data through the Centers for Medicare & Services (CMS) Payroll-Based Journal (PBJ) system, in order to demonstrate compliance with federal and state staffing transparency requirements and to support quality of care for residents.A review of the policy also revealed, The facility maintains processes to ensure that staffing hours are recorded accurately, categorized correctly, and submitted to CMS via the PBJ system within required reporting timeframes.N.J.A.C. 8:39-25.2(b)3

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain a clean, safe and sanitary environment for 2 of 2 units, the 1st and 2nd floor units, reviewed for environment.This deficient practice was evidenced by the following: On 12/29/2025 at 9:45 AM, on the 2nd floor in Bedroom [ROOM NUMBER], surveyor # 1 observed a fall mat positioned next to a resident's bed that contained multiple brown debris spots. On 12/29/2025 at 10:00 AM, on the 2nd floor in Bedroom [ROOM NUMBER], surveyor # 1 observed unfinished spackling on the wall behind the headboard of the B bed. Three holes were observed in the wall near the dresser. A fall mat was present on the right side of the bed with multiple areas of white debris. The floor on the left side of the bed contained a plastic fork, a knife, a paper cup, and multiple areas of brown debris and food. The bathroom contained a drop ceiling that was brown-stained and bulging. On 12/30/2025 at 9:55 AM, on the 2nd floor in Bedroom [ROOM NUMBER], surveyor # 1 observed chipped paint on the entrance door, and the unit's thermometer had exposed wiring with the protective top cover missing. During an interview with surveyor # 1 on 01/02/2026 at 12:20 PM, the LNHA stated that the issues identified do not reflect a homelike environment. The facility is aware of the infrastructure concerns and is working to improve them. A review of the facility's policy dated 09/2025, titled Homelike Environment, revealed that facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a.) a clean, sanitary, and orderly environment. On 12/29/2025 at 09:40 AM during initial tour of the 2nd floor unit surveyor # 2 observed broken blinds in room [ROOM NUMBER]. On 12/29/2025 at 10:10 AM during the initial tour of the 1st floor, surveyor # 2 observed in room [ROOM NUMBER] broken blinds and the sink leaking out the bottom when turned on. On 12/30/2025 at 09:49 AM during rounds on the 2nd floor unit, surveyor # 2 observed in the low side shower room the following: 1. No cover on the drain in the shower room floor. 2. Cracks in the ceiling. 3. An open pipe in the wall where a shower fixture had once been. 4. Molding on the floor peeling and noted with a black substance on them. 5. The bottom of the sink cabinet warped and peeling. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/02/2026 at 10:53 AM with the surveyors, the maintenance director (MD) said he rounds twice daily and if there are any concerns that come up the staff will add them to the maintenance book. The MD said if she sees broken blinds they replace them right away and they should not be broken. When asked about the shower room the MD simply said, I will fix it. During an interview on 01/02/2026 at 12:44 PM with the surveyors, the Licensed Nursing Home Administrator (LNHA) said that the blinds and sink should not be broken and agreed that the shower room was not in good repair. The LNHA also said that they had identified the environmental concerns and were prioritizing what needed to be fixed and updated. A review of a facility provided policy titled Homelike Environment revealed, The facility staff and management maximize, the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a. clean, sanitary and orderly environment. On 12/29/2025 at approximately 10:00 am during initial tour of the 1st floor unit, surveyor #3 observed the following: In the bathroom of Bedroom [ROOM NUMBER], Surveyor # 3 observed no toilet paper on the roll, no additional toilet paper rolls, a stained ceiling tile, the commode over the toilet seat was missing the left arm rest and a screw protruding up on the commode. In Bedroom [ROOM NUMBER], Surveyor # 3 observed no paper towels were available in the bathroom. In Bedroom [ROOM NUMBER], Surveyor # 3 observed a light bulb was not functioning in the bathroom. In Bedroom [ROOM NUMBER] A side, Surveyor # 3 observed four chest dresser with two drawers that could not close. In Bedroom [ROOM NUMBER], Surveyor # 3 observed a missing toilet paper holder, the toilet paper kept on the lid of the toilet seat, and a stained ceiling tile. On 12/31/2025 at 09:55am on the 1st floor unit in bedroom [ROOM NUMBER], surveyor # 3 observed a brown stain on the curtains dividing the room. N.J.A.C. 8:39-31.4(a)

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. Based on observations on 12/31/2025 and 01 02/2026 in the presence of the facility's Corporate Regional Maintenance (CRM) and Maintenance Director (MD), it was determined that the facility failed to ensure that corridors were equipped with firmly secured handrails on both sides, This deficient practice had the potential to affect the 101 Residents who reside in the facility and is evidenced by the following:During the building tour on 01/02/2026 in the presence of the facility's CRM and MD at approximately 9:50 AM, the surveyor observed on the ground floor corridor next to the elevator and lobby area had no evidence of hand rails on both sides of the corridor.The surveyor measured and recorded the following sections of wall with no evidence of hand rails,1) One 3' section of wall with no hand rail.2) One 10' section of wall with no hand rail.3) One 7'-6 section of wall with no hand rail.4) One approximately 18 foot section of wall with no hand rail.The CRM and MD confirmed the findings at the times of observations.NJAC 8:39-31.2 (e).

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure newly hired employees were properly screened for a history of abuse, neglect, exploitation, or misappropriation and failed to implement policies and procedures related to pre-employment screening. Specifically, the facility did not complete required license verifications, reference checks, or criminal background checks prior to the start of employment. This deficient practice was identified in 53 of 160 employee files reviewed (Employees #1 through # 53).The deficient practice was evidenced by the following: On 12/30/2025 at 9:15 AM, the surveyor requested that the Licensed Nursing Home Administrator (LNHA) and Human Resources Director (HRD) provide personnel files for all employees hired since the last annual recertification survey in 06/2024, regardless of current employment status. The requested documentation included the department of hire, date of hire, license verification, reference checks, criminal background checks, and pre-employment medical documentation, including physical examinations and two-step Mantoux test results (a simple skin test used to see if a person has been exposed to a germ that can affect the lungs). On 12/30/2025 at 10:15 AM, the surveyors began reviewing the personnel files of 160 newly hired employees. Of the personnel files reviewed, 53 indicated there was no evidence that license verifications, reference checks, or criminal background checks were completed prior to the start of employment. The review of the personnel files of all newly hired employees revealed the following: Employee # 1 was hired and began working at the facility on 10/01/2025. There was no evidence that a reference check was completed prior to the start of employment. Employee # 2 was hired and began working at the facility on 04/21/2025. There was no evidence that a license check was completed prior to the start of employment. Employee # 3 was hired and started working at the facility on 03/15/2025. There was no evidence that a reference check was completed prior to the start of employment. Employee #4 was hired and began working at the facility on 10/15/2025. There was no evidence that a criminal background check was completed prior to the start of employment. Employee #5 was hired and began working at the facility on 07/30/2024. The criminal background check was not completed within the required timeframe prior to the start of employment. The background check was completed on 07/31/2024. Employee #6 was hired and began working at the facility on 12/23/2025. There was no evidence that a reference check or a criminal background check was completed prior to the start of employment. Employee # 7 was hired and began working at the facility on 04/19/2025. There was no evidence that a reference check or a criminal background check was completed prior to the start of employment. Employee # 8 was hired and began working at the facility on 04/21/2025. There was no evidence that a reference check or a criminal background check was completed prior to the start of employment. Employee # 9 was hired and began working at the facility on 10/15/2025. There was no evidence that a reference check or a criminal background check was completed prior to the start of employment. Employee # 10 was hired and began working at the facility on 11/26/2025. There was no evidence that a criminal background check was completed prior to the start of employment. Employee # 11 was hired and began working at the facility on 03/15/2025. There was no evidence that a reference check or a criminal background check was completed prior to the start of employment. Employee # 12 was hired and began working at the facility on 01/16/2025. There was no evidence that a reference check or a criminal background check was completed prior to the start of employment. Employee # 13 was hired and began working at the facility on 07/27/2024. There was no evidence that a license verification, a reference check or a criminal background check was completed prior to the start of employment. Employee # 14 was hired and began working at the facility on 10/10/2024. There was no evidence that a criminal background check was completed prior to the start of employment. Employee # 15 was hired and began working at the facility on 03/09/2024. The criminal background check was not completed within the required timeframe prior to the start of employment. The background check was completed on 06/27/2024. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee # 16 was hired and began working at the facility on 10/15/2024. There was no evidence that a reference check was completed prior to the start of employment. Employee # 17 was hired and began working at the facility on 10/10/2025. There was no evidence that a reference check was completed prior to the start of employment. Employee # 18 was hired and began working at the facility on 09/11/2025. The criminal background check was not completed within the required timeframe prior to the start of employment. The background check was completed on 09/16/2025. Employee # 19 was hired and began working at the facility on 12/22/2025. There was no evidence that a license verification was completed prior to the start of employment. Employee # 20 was hired and began working at the facility on 07/30/2025. There was no evidence that a reference check or a criminal background check was completed prior to the start of employment. Employee # 21 was hired and began working at the facility on 11/04/2024. There was no evidence that a license verification, a reference check or a criminal background check was completed prior to the start of employment. Employee # 22 was hired at the facility, but no hire date was documented in the personnel files. There was no evidence that a license verification, a reference check or a criminal background check was completed prior to the start of employment. Employee # 23 was hired and began working at the facility on 06/21/2024. There was no evidence that a criminal background check was completed prior to the start of employment. Employee # 24 was hired at the facility, but no hire date was documented in the personnel files. There was no evidence that a license verification, a reference check or a criminal background check was completed prior to the start of employment. Employee # 25 was hired at the facility, but no hire date was documented in the personnel files. There was no evidence that a license verification, a reference check or a criminal background check was completed prior to the start of employment. Employee # 26 was hired and began working at the facility on 08/12/2025. There was no evidence that a license verification was completed prior to the start of employment. Employee # 27 was hired and began working at the facility on 03/07/2025. There was no evidence that a reference check was completed prior to the start of employment. Employee # 28 was hired and began working at the facility on 04/10/2025. There was no evidence that a license verification or a criminal background check was completed prior to the start of employment. Employee # 29 was hired and began working at the facility on 11/12/2025. There was no evidence that a reference check was completed prior to the start of employment. Employee # 30 was hired and began working at the facility on 10/21/2024. There was no evidence that a reference check was completed prior to the start of employment. Employee # 31 was hired and began working at the facility on 07/18/2024. There was no evidence that a reference check was completed prior to the start of employment. Employee # 32 was hired and began working at the facility on 12/01/2024. There was no evidence that a license verification was completed prior to the start of employment. Employee # 33 was hired and began working at the facility on 07/15/2024. There was no evidence that a license verification was completed prior to the start of employment. Employee # 34 was hired and began working at the facility on 11/18/2024. There was no evidence that a license verification was completed prior to the start of employment. Employee # 35 was hired and began working at the facility on 12/09/2025. There was no evidence that a reference check was completed prior to the start of employment. Employee # 36 was hired and began working at the facility on 07/12/2024. There was no evidence that a license verification was completed prior to the start of employment. Employee # 37 was hired at the facility, but no hire date was documented in the personnel files. There was no evidence that a license verification, a reference check or a criminal background check was completed prior to the start of employment. Employee # 38 was hired and began working at the facility on 02/08/2025. There was no evidence that a criminal background check was completed prior to the start of employment. Employee # 39 was hired and began working at the facility on 06/29/2024. There was no evidence that a reference check was completed prior to the start of employment. Employee # 40 was hired at the facility, but no hire date was documented in the personnel files. There was no evidence that a license verification, a reference check or a criminal background check was completed prior to (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the start of employment. Employee # 41 was hired and began working at the facility on 09/11/2024. There was no evidence that a reference check was completed prior to the start of employment. Employee # 42 was hired and began working at the facility on 07/22/2025. There was no evidence that a criminal background check was completed prior to the start of employment. Employee # 43 was hired and began working at the facility on 10/15/2025. There was no evidence that a reference check or a criminal background check was completed prior to the start of employment. Employee # 44 was hired and began working at the facility on 09/30/2024. There was no evidence that a license verification was completed prior to the start of employment. Employee # 45 was hired and began working at the facility on 10/02/2024. There was no evidence that a reference check was completed prior to the start of employment. Employee # 46 was hired and began working at the facility on 06/26/2025. There was no evidence that a criminal background check was completed prior to the start of employment. Employee # 47 was hired and began working at the facility on 03/08/2025. There was no evidence that a criminal background check was completed prior to the start of employment. Employee # 48 was hired and began working at the facility on 10/02/2024. There was no evidence that a reference check was completed prior to the start of employment. Employee # 49 was hired and began working at the facility on 06/03/2024. There was no evidence that a license verification was completed prior to the start of employment. Employee # 50 was hired and began working at the facility on 10/15/2024. There was no evidence that a license verification was completed prior to the start of employment. Employee # 51 was hired and began working at the facility on 12/03/2025. There was no evidence that a reference check was completed prior to the start of employment. Employee # 52 was hired and began working at the facility on 12/12/2024. There was no evidence that a reference check was completed prior to the start of employment. Employee # 53 was hired and began working at the facility on 12/09/2024. There was no evidence that a reference check was completed prior to the start of employment. During an interview on 01/02/2026 at 11:45 AM, the HRD stated that background checks, reference checks, and license or certified nurse aide (CNA) verifications are completed before employees begin work. The HRD noted that reference checks may be inconsistent for staff converted from agency positions, only one reference may be documented using agency verification. The HRD emphasized that completing these checks is important for knowing who is brought into the facility, especially when working with residents. During an interview with the surveyor on 01/02/2026 at 12:20 PM, the LNHA stated that personnel files need improvement and must include the DOH, license verification, two reference checks, criminal background checks, and documentation of a pre-employment physical examination and Mantoux test completed prior to starting work at the facility. These requirements help ensure resident safety. A review of the facility's policy dated 09/2025, titled Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident Property revealed 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. N.J.A.C. 8:39-9.3 (b)

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	315124	A. Building B. Wing	01/05/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Complaint # 366635Based on interview and record review, it was determined that the facility failed to report an allegation of a resident-to-resident altercation to the Department of Health (State Agency) within the required 24-hour time frame. This deficient practice was identified for 2 of 8 residents (Resident # 113 and 114) reviewed under Abuse.The deficient practice was evidenced by the following:A review of the facility's AAS-45 (official report that a nursing home must send to the state government whenever an accident or incident happens to a resident) revealed that a resident-to-resident altercation occurred on 11/27/2024.A review of the AAS-45 revealed the form indicated that no injuries were reported because of the altercation.A review of the AAS-45 revealed the facility indicated the event was called into the Department of Health on 11/28/2024.A review of the AAS-45 revealed that the section for the date of the report was 12/12/2024.A review of the NJ Department of Health Intake Information sheet revealed the Department received the intake via E-Mail on 12/13/2024, approximately 16 days after the incident.On 1/02/2026 at 10:13 AM, during an interview with the surveyor, the Director of Nursing (DON) stated the date on the AAS-45 was a typographical error and the incident would have been reported on the date it occurred. The DON could not provide documentation to support that the notification was made within the required time frame.On1/02/2026 at 12:26 PM during an interview with the Licensed Nursing Home Administrator, she stated that reporting allegations of abuse must be completed within two hours if there is harm and twenty-four hours if there hasn't been.A review of the facility-provided policy titled Abuse Policy under G. Reporting and Response revealed that the facility will ensure that all alleged violations involved abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency).N.J.A.C. 8:39-9.4(f)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Complaint # 366660Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to conduct a thorough investigation into an allegation of abuse by failing to document witness statements regarding the specific events of an alleged incident and instead focused on the character of the staff member involved. The deficient practice was identified for 1 of 8 residents (Resident # 112).The deficient practice was evidenced by the following:On 6/10/2025, Resident # 112 reported to the New Jersey Department of Health that on 5/02/2025, a nurse refused to give the resident needed supplies to perform their own care, kicked an oxygen concentrator, and refused to send the resident to the hospital.A review of Resident # 112's Electronic Medical Record (EMR) revealed under Care Plan that the resident had a focus of Behavior issues secondary to anxiety disorder as evidenced by: Calling 911, exaggerating events, Screaming to the point of exhaustion, yelling causing distress to self and others, extreme responses to ordinary stimuli or minor inconvenience, easily irritated/agitated, fixating.A review of the Facility-provided Investigation File revealed four witness statements.A review of the four witness statements revealed that none of the statements referred to any details regarding the incident alleged to have occurred on 5/02/2025.A review of the four witness statements revealed the statements only reflected positive personality attributes about the involved nurse.On 12/31/2025 at 10:53 AM, during an interview with the surveyor, the Director of Nursing (DON) stated Resident # 112 alleged the oxygen concentrator was broken and that the facility had the resident's documents, which the facility did not have.During the same interview, the surveyor noted that the summary of the investigation revealed, Employees interview regarding care provided by [Licensed Practical Nurse/LPN] # 1.During the same interview, the surveyor asked the DON for the documentation of those interviews. The DON referred to the Witness Statements and informed the surveyor that she was looking for more.During the same interview, the surveyor asked the DON if any of the four witness statements discussed the incident itself.The DON replied, No, we basically kept it like neutral saying we interview residents and staff.A review of the facility-provided policy titled Abuse Policy revealed that an investigation of abuse will include: i. Who was involved; ii. Residents' statements; iii. Resident's room mate statements; iv. Involved staff and witness statements of events.N.J.A.C. 8:39-9.4(i)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, and review of facility provided documentation, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication observations conducted from 12/30/2025 to 01/02/2026, the surveyors observed four nurses administer medications to ten residents. There were 29 opportunities, and 3 errors observed, which resulted in a medication error rate of 10.34%. This deficient practice was identified for 2 of 10 residents, administered by 1 of 4 nurses. The deficient practice was evidenced by the following:On 12/30/2025 at 9:24 AM, the surveyor observed Licensed Practical Nurse (LPN) # 1 begin to administer medications for resident #63. LPN # 1 emptied 1 tablet of potassium chloride (a supplement used to treat or prevent low blood potassium) 10 milliequivalents from the medication card into a medication cup. Review of the Medication Administration Record (MAR) showed Potassium Chloride tab 10MEQ ER, Give 1 tablet orally one time a day every 2 days, at 8:00 AM. Administration documented at 9:31 AM, which was 31 minutes late per facility policy. On 12/30/2025 at 9:32 AM, the surveyor observed LPN #1 gesture to the screen of her computer. LPN #1 stated to the surveyor that resident #32 took his/her Metformin (a medication used to treat high blood sugar) with breakfast, but she did not document the medication as administered at the time of administration. LPN #1 then proceeded document the medication as administered in the Electronic Medical Record (EMR). At that time, the Metformin in the EMR changed from red to green highlight. The surveyor asked what red means on the EMR, LPN #1 stated red indicated the medication was late.A review of the MAR revealed Metformin HCl Oral Tablet 1000 MG, Give 1 tablet by mouth two times a day with meals. The morning dose was ordered at 8:00 AM, and signed out at 9:33AM.LPN #1 proceeded to pour Aspirin 81mg chewable from a medication bottle for Resident #32. The medication was administered with water to the resident. Review of the MAR reflected an order for Aspirin 81mg Enteric Coated (EC) delayed release, not the chewable tablet that was administered. On 12/31/2025 at 11:48 AM, a review of the policy titled Administering Medications, last updated 07/2025 revealed under Policy Interpretation and Implementation that, 4. Medications are administered in accordance with prescriber orders, including any required time frame. And 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). N.J.A.C. 8:39-29.2 (d)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to ensure medications were properly labeled and stored in an orderly manner. The facility failed to label opened multi-dose insulin vials with an open or expiration date and failed to maintain a medication cart free from loose, scattered medication. This deficient practice was identified for 1 of 2 medication carts inspected under the Medication Storage and Labeling task.The deficient practice was evidenced by:On 12/30/2025 at 10:34 AM, the surveyor inspected the 2 High - Side, 2nd Floor medication cart in the presence of Licensed Practical Nurse (LPN) # 1.While inspecting the top drawer of the cart, the surveyor observed a multi-dose vial of Lantus insulin (long-acting insulin) prescribed to an unsampled resident.The vial was in a clear, plastic bag and was observed to be opened but was not labeled with an opened date or an expiration date.The surveyor also observed a multi-dose vial of Humulin 70/30 insulin in the same drawer that did not have an expiration date labeled on it.While inspecting the second drawer from the top of the same medication cart, the surveyor discovered 15 loose medication tablets and pills scattered across the bottom of the drawer.At that time, LPN # 1 informed the surveyor that the staff check the medication cart weekly for loose tablets and pills.On 1/02/2026 at 12:26 PM, during an interview with the surveyor, the Director of Nursing (DON) stated that the facility's expectation is that insulin vials are dated.A review of the facility's policy titled Administering Medications revealed that, 13. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.A review of the facility's policy titled Medication Labeling and Storage revealed that, 5. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems.N.J.A.C. 8:39-29.4(g)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and review of facility documents, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage containers closed and provide an area free of garbage and debris for 3 of 3 garbage containers. This deficient practice was evidenced by:On 12/30/2025 at 12:15 PM, the surveyor, accompanied by the Director of Dining (DOD), observed the facility's outdoor trash disposal area. The surveyor observed three garbage containers (GC) situated side by side along the exterior fence. The three GCs had an open lid and contained trash that was exposed to the elements. The area surrounding the three GCs was littered with debris, including but not limited to disposable gloves, plastic bags, and cardboard boxes. On 01/02/2026 at 10:53 AM, during an interview with the surveyor, the Director of Maintenance (DOM) stated that both housekeeping and the maintenance departments are responsible for keeping the dumpster area clean. The DOM stated the GCs should be shut and the area surrounding the GCs should be clean. On 01/02/2026 at 11:04 AM, during an interview with the surveyor, the Environmental Service Director (ESD) stated that the GCs should remain free from debris and the lids should be closed. The ESD stated that the GCs are monitored at least twice a day and when other staff empty their garbage into the GC.The surveyor reviewed the facility's Garbage and Refuse policy, dated 09/01/2025, which reflected that All garbage/refuse containers in utility rooms, refuse storage rooms, and outside facility must be maintained at all times with a closed lid. The same policy reflected, Garbage/refuse pickup will be as often as necessary to prevent sanitary nuisance conditions. NJAC 8:39-19.3(c)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure proper infection prevention and control practices were implemented to prevent the transmission of infection, related to handling of an indwelling urinary catheter for 1 of 1 resident reviewed for Urinary Catheter. (Resident # 11)The deficient practice was evidenced by the following: During the initial tour of the unit on 12/29/2025 at 09:52 AM, Resident #11 was in bed with an indwelling catheter. The catheter drainage bag was in contact with the floor with no privacy bag.A review of Resident # 11's admissions record revealed that, Resident # 11 was admitted with but not limited to Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms (enlarged prostate), and Obstructive and reflux uropathy (a condition where urine flow is blocked.A review of the Resident #11's admission Minimum Data Set (MDS) dated [DATE] revealed under section H that the resident had an indwelling catheter.On 01/02/2026 at 09:32 AM during an interview with the surveyor, the Infection Prevention (IP) nurse stated, indwelling catheters should be hung below the bladder and in a privacy bag. The IP also said that indwelling catheters should always be in privacy bags and never on the floor for infection control reasons. On 01/02/2026 at 12:44 PM, during an interview with the surveyor, the Director of Nursing (DON) said indwelling catheters should never be on the floor and should be hung below the bladder in a privacy bag.A review of a facility policy title Catheter Care, Urinary revealed under Infection Control to, Be sure the catheter tubing and drainage bag are kept of the floor. N.J.A.C. 8:39-19.4(a)