

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2025
NAME OF PROVIDER OR SUPPLIER Trenton Gardens Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 512 Union Street Trenton, NJ 08611	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: 2562900 Based on interviews, medical record reviews, and review of pertinent facility documentation on 7/22/25 and 7/23/25, it was determined that the facility failed to ensure the safety of a resident (Resident #3) with a known history of illicit drug use with multiple overdoses in the facility who overdosed in the facility on 7/11/25, by: A) monitoring and supervising the resident to ensure illicit drugs were not obtained or used and B.) developing and/or implementing care plan interventions to protect the resident from obtaining illicit drugs and preventing overdoses. This deficient practice was identified for 1 of 14 residents reviewed (Resident #14). On 7/11/25 at approximately 4:30 PM, the Registered Nurse (RN) Supervisor was called to main lobby regarding Resident #3 being found unresponsive with pinpoint pupils by the main elevator. Emergency services (911) were called, and the resident was administered Narcan (a medication to reverse opioid overdose). The resident was transported to the hospital for evaluation and the facility was notified that the resident received Narcan in the emergency room (ER) and was now stable. Interviews with staff on 7/22/25, confirmed that the resident had overdosed on illicit drugs in the facility. A review of the medical record revealed this was the resident's seventh overdose in the facility since November of 2024. The facility's failure to monitor and supervise Resident #3 who had a known history and six previous illicit drug overdoses in the facility placed Resident #3 and all other residents at risk for accidental drug overdoses. This posed the likelihood for serious harm, impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 7/11/25 at 4:30 PM, when Resident #3 was found unresponsive in the main lobby and administered Narcan. The facility's Administration was notified of the IJ on 7/23/25 at 5:37 PM. An acceptable Removal Plan was received on 7/25/25 at 10:26 AM. The Removal Plan was verified on-site by the surveyor on 7/29/25. The deficient practice was evidenced by the following: A review of the facility's undated policy titled Policy on Illegal Drug Use included the facility complies with all laws, regulations, and other requirements related to substance abuse. Policy Interpretations and Implementation: 1. All residents admitted to the facility will be asked to sign a contract showing they understand that illegal drugs use (possession, taking of drugs or possession with intent to sell) is not allowed in the facility [.] 2. All residents may be subject to random room searches to ensure illegal substances are not being held within the facility. Any items found during the search will be removed, logged and locked in a designated area until the police are able to collect the items found. 4. Residents identified as high risk for illegal drug use by the nursing department will be subject to be searched/have their bags searched by Security or Nursing upon return from authorized Out on Pass Visit. Security is to inform the Nurse in charge/ Director of Nursing (DON) immediately if any resident is found with illegal substances and police will be called. 5. In the event illegal drugs are found on a resident the following procedure must occur: [.] Incident report to be completed-Investigate how the resident received the illegal drugs and put interventions in place to prevent reoccurrence. The surveyor reviewed the medical record for Resident #3. According to the admission Record face sheet (admission summary), Resident #3 was admitted to the facility with diagnoses which included but were not limited to: opioid dependence, hypertension (high blood pressure), and muscle weakness. According to the Minimum Data Set (MDS), an assessment tool dated 7/13/25, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident's cognition was intact. A review of the Progress Notes (PN) revealed the resident had overdosed from illicit drugs in the facility on 11/1/24, 11/28/24, 1/18/25, 1/28/25, 3/7/25, 3/30/25, and 7/11/25. A review of the PN dated 7/11/25 at 5:51 PM, completed by the Registered Nurse (RN), revealed that at approximately 4:30 PM, she was called to the main lobby regarding a resident's current status. Upon assessment, the resident was found unresponsive by main elevator. The resident was brought to the unit and sternal rub (rubbing the flat bone (sternum) of the chest) was performed and emergency services (911) was called. The resident's vital signs were obtained, and their pupils were pinpoint. Upon Emergency Medical Services' (EMS) arrival, the resident was placed on a non-rebreather (a mask that provides high amounts of oxygen in an emergency situation) and put on a stretcher and sent to the hospital for evaluation. A review of the PN dated 7/11/25 at 5:57 PM, indicated that a call was placed to the hospital at 5:40 PM, to obtain the resident's status. The resident was given Narcan in the emergency room (ER) and was now stable. A review of Resident #3's Care Plan (CP) included a focus area dated 10/17/24, and revised 6/12/25, that the resident had a history of opioid dependence, chronic back pain on 5/9/25 had a history and potential risk for illicit drug abuse and overdose. The goal initiated on</p>