STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315324	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trenton Gardens Rehabilitation and Nursing Center	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. (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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # NJ 2587050Based on observation, interview and document review, it was determined that the facility failed to maintain a clean, comfortable and homelike environment by failing to ensure a) resident rooms, including personal belongings and common areas were kept clean, sanitary, free of pests and ensuring soiled meal trays were removed in a timely manner, b) furniture and resident rooms and common areas were maintained in a clean and homelike manner, and c) resident excrement was cleaned up timely to limit odors. The deficient practice was identified for 4 of 4 residents who attended a resident council meeting and observed on 3 of 3 resident units (2nd, 3rd and 4th floor).The deficient practice was evidenced by the following:Based on observation, interview and document review it was determined On 12/2/25, Surveyor #1 conducted an initial tour of the facility on the second floor, and observed the following:At 7:36 AM, the ice machine located in the dining room, had a plastic type ice shoot that was heavily soiled with white and black colored substances. The drain cover had a rust like build up. The molding around the ice machine was peeling and a hole was noted on the wall by the ice machine. The floor under the countertop where the ice machine rested was covered with black substances.At 7:49 AM, a food cart was adjacent to the nursing station. The food cart contained left over and uncovered food items from the prior evening meal.At 8:05 AM, Surveyor #1 entered Resident #135's room with two Certified Nurse Aides (CNA's) to observe incontinence care. The bathroom floor was covered with various debris, which included used plastic bags, a broken toilet seat was also observed on the floor. While in the room with the CNAs the surveyor observed a brownish cockroach type bug crawling on the wall. Upon inquiry, the CNA's informed the surveyor that the facility had roaches. The surveyor then asked the CNA's what the protocol was if staff observed cockroaches. The staff informed the surveyor that they would enter their observations into the pest control book which was located at the nurses' station and they would also notify the Maintenance Director (MD).At 8:15 AM, the surveyor reviewed the pest control book that was located at the nurses' station and reviewed the pest control book. According to the data entered in the book, there was documentation regarding staff observations and cockroaches on the 2nd floor, and in resident's rooms dating back to 7/17/25. At 8:18 AM, the surveyor entered room [ROOM NUMBER] and observed a pile of soiled linen on the floor. At 8:20 AM, Resident #100's room had food debris, including straws and a red substance that was splattered on the floor. A CNA stated the red substance was food debris. The surveyor also observed the wall in the room appeared to be bulging, and the ceiling area over the light appeared to have water stains. On 12/2/25 at 8:45 AM, Surveyor #2, conducted an initial tour of the facility on the third floor and observed the following:The ice machine located in the dining room had blackened areas inside the ice chute, the area also had blackened discolored areas where the ice chute attached to the machine and where a receptacle would be placed to catch the ice. The lower part of the ice machine also appeared soiled and stained in the drain area.Resident #3's nightstand had a triangular piece of the corner finish chipped off, the edge of the drawer and the sides of the nightstand also had chipped off finish and was not smooth.On 12/2/25 at 7:30 AM, Surveyor #3 conducted an initial tour of the facility on the fourth floor and observed the following:The ice machine located in the dining room had blackened areas inside the ice chute and where the ice would be collected in a receptacle. The drain area on the ice machine had embedded blackened and white areas, and various spatter type debris was located on the exterior of the ice machine. Room # 424: The surface coating of the bathroom countertop was cracked on the edge, had missing material with an exposed rough area by the sink area. An infusion pump on a pole was located next to the wall where the air conditioner unit was located. The lower portion of the wall had broken wall board and exposed the internal wall area. The molding was also missing.room [ROOM NUMBER]: The surface material around the sink in the bathroom was broken on the edges with sharpened type areas. The area behind the bed had a sunken-in wall area with many marked ripped areas. An interview with the Licensed Practical Nurse/ Unit Manager (LPN/UM) at that time revealed that the LPN/UM acknowledged the damage to the wall and countertop and stated it was in disrepair and should not look like that. On 12/04/25 at 9:49 AM, Surveyor #2 conducted a resident council meeting with four residents. Four of four residents stated that there were cockroaches in the facility and the residents stated they observed cockroaches in their bathroom, bedrooms, on the beds and 1 of 1 resident stated the cockroaches were inside of their closet. On 12/04/25 at 12:30 PM, Surveyor #2 and #4 observed Resident #31's room. Resident #31 allowed the surveyors to observe their closet for cockroaches. Upon opening the closet door, both

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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 - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #s NJ 388773, NJ 2573609, NJ 2595473, NJ 263559, NJ 2591993Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that residents who were dependent on staff for care were provided with a) routine and appropriate incontinence care and b) provided with care to maintain their fingernails in a clean manner. This deficient practice was identified for 3 of 4 residents reviewed for Activities of Daily Living (Resident #11, #81 and Resident #135. The deficient practice was evidenced by the following: 1. On 12/02/25 at 7:50 AM the surveyor observed Resident # 11 lying in bed, the resident was awake and alert and the surveyor further observed that the resident's fingernails were long and jagged with a black substance underneath all of the nails.On 12/04/25 at 8:25 AM, the surveyor again observed Resident #11's fingernails were not cleaned trimmed. During an interview with the surveyor, the resident stated, I would like them to be trimmed and cleaned.On 12/05/25 at 11:30 AM, the surveyor again observed Resident #11's fingernails and the resident's fingernails were not trimmed or cleaned after being assisted with morning care.On 12/05/25 at 11:40 AM, the surveyor interviewed the Unit Manager regarding what should be completed for resident nail care. The Unit Manger (UM) stated that residents nails were supposed to be trimmed and cleaned with the weekly skin assessment. The surveyor reviewed the shower log with the UM, and observed that Resident #11's shower schedule was every Wednesday. Resident #11 had a shower on Wednesday 12/3/25, and nail care was not completed. Review of the resident's December Physician Order Sheet (POS) did not reveal a Physician's Order (PO) for fingernail care. The POS included an order for skin assessment every Monday on the 3:00 PM-11:00 PM shift.On 12/5/25 at 12:15 PM, the surveyor reviewed Resident #11's admission Record which reflected that the resident had diagnoses which included, but was not limited to; difficulty in walking, contracture left foot, and adjustment disorder with mixed anxiety and depressed mood. The Quarterly Minimum Data Set (MDS) dated [DATE], coded Resident #114 as being of intact cognition. Resident #11 scored 15 out of 15 on the Brief Interview for Mental Status. (BIMS) Normal Score 15. Section GG of the MDS which addressed functional status reflected that Resident #11 required assistance with care. The interventions where staff will encourage the resident to perform tasks, they are physically capable of. Staff will assist with 2 staff members when appropriate. 2. On 12/02/25 at 8:02 AM, the surveyor observed Resident #81 in bed. During an interview with the resident, they informed the surveyor that they had not received incontinence care or had been repositioned since 9:30 PM last night.On 12/02/25 at 8:34 AM, the surveyor interviewed the resident's Certified Nurse Aide (CNA) who stated that the resident informed him that they had not seen a CNA last night. They resident stated they were leaning against the siderail for the night and staff did not come to the room when they activated the call light.On 12/02/25 at 8:35 AM, the surveyor performed an incontinence check with the CNA assigned to the resident. Resident #81 was saturated with urine, and the bedding, including the pad were soaked with urine and were yellow stained The CNA assigned to Resident #81 for the morning shift stated that he was not aware that the resident had not been changed. The CNA further stated he did not receive report from the 11:00 PM - 7:00 AM shift, and he repositioned the resident this morning but did not provide incontinence care. Resident #81 had was observed with some redness on the buttocks and groin areas and the skin was not opened. The CNA stated that the night shift staff were supposed to check and change the residents, prior to leaving, at the end of the shift.Resident # 81's admission Record reflected the resident had diagnoses which included, but were not limited to; multiple sclerosis, cognitive communication deficit, paraplegia (loss of motor and sensory function in the lower half of the body) major depressive disorder and anemia.Review of the most recent quarterly MDS, dated [DATE], indicated that Resident #81's cognitive skills for decision making were intact. Resident #81 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS). A further review of the resident's MDS, Section GG - Functional Status indicated that the resident required one-person physical assist with personal hygiene.Review of the resident's Care Plan revised on 10/30/23, reflected a focus area that the resident had preferences and interventions to help maintain his/her quality of life and assist with daily choices. Initiated 10/30/2023. The goal of the resident's Care Plan was that the resident's preferences will be honored and updated as they changed. Initiated 10/30/2023 with a target date of 01/25/26. The interventions for the resident's ADL Care Plan included to provide care, Resident #81 was a total care, to assist with baths and showers and assist with incontinence care. On 12/02/25 at 12:05 PM, the surveyor interviewed the Licensed Practical Nurse Unit

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # 2673152 Based on observation, interview, and record review, it was determined that the facility failed to ensure adequate supervision was provided to a cognitively impaired resident with a history of being restless and impulsive and a history of falls, who sustained a fracture during an unreported episode of restlessness. On 11/18/25, Resident #114 was grimacing in pain and guarding their left arm. An x-ray revealed an acute non-displaced fracture of the left clavicle (broken collarbone), and it was determined that the facility did not implement care plan interventions prior to the discovery of the fracture when the resident was restless. This deficient practice was identified for 1 of 2 residents reviewed for falls (Resident #114). The evidence was as follows: A review of the facility's Policy and Protocol for Incident Reporting, last revised 11/2025, indicated the following: The facility is committed to keeping all resident's safe, maintain highest resident function and adhere to Federal and State regulations. An Accident and Incident report will be completed and investigated by the management team. The Interdisciplinary Team will discuss and attempt to determine the root cause and care plan interventions decided by the team will be implemented. Trending and tracking incidents will be done by the team and reported to the quality council to discover cause and/ or trends through this process. The Administrator and/ or Director of Nursing will process all Reportable Events to the advocacy agencies required by state and federal regulations.The Director of Nursing or the Licensed Nursing Home Administrator will review incidents with the Medical Director. On 12/02/25 at 11:44 AM, the surveyor toured the nursing unit and observed Resident #114 seated in a recliner chair in the hallway near the nursing station. Resident #114 was confused and could not be interviewed. On 12/04/25 at 9:20 AM, the surveyor observed Resident #114 seated in a recliner chair in the hallway by the nursing station with their eyes closed. The surveyor observed the resident with a sling (a flexible strap or belt used in the form of a loop to support or raise a weight) to their left arm. The resident had a tray table in front of the recliner chair, and staff were noted entering and leaving the nursing station and ambulating in the hallway. There was no staff in attendance at the nursing station, and three other residents were noted in the dayroom. On 12/05/25 at 12:38 PM, the surveyor observed Resident #114 in the hallway eating lunch. During a conversation with the resident, it was noted that the resident was very confused and could not answer questions appropriately. On 12/05/25 at 12:50 PM, the surveyor reviewed Resident #114's medical record. A review of the admission Record face sheet (an admission summary), reflected that Resident #114 was admitted to the facility with diagnoses which included but were not limited to; unspecified dementia, unspecified severity without behavioral disturbance, cognitive communication deficit, muscle weakness, unspecified abnormalities of gait and mobility, and displaced fracture of lateral end of left clavicle (onset 11/19/25). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 10/01/25, reflected that Resident #114 had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated the resident had severe cognitive impairment. The facility used the Morse Fall Scale (Fall Risk Assessment) to assess Resident #114's risk of falling to implement preventive measures before a fall occurred. Resident #114 received a score of 75 on admission. According to the Fall Risk Assessment, 0-24 points were no risk; 25-50 points were low risk; and greater than (>) 50 points were high risk. A review of Resident #114's comprehensive care plan (CP) provided by the facility on 12/05/25, revealed a focus area initiated on 07/11/25, that [Resident #114] is at high risk for falls related to poor safety awareness, unsteady gait. The goal initiated on 07/11/25, was that Resident #114 will suffer no fall related injury. Another goal initiated on 08/12/25, was that Resident #114 will be safe. The interventions included Resident #114 will continue to receive rehabilitation for strengthening and energy conservation, initiated 07/23/25. Resident #114 had a floor mat in place when in bed for safety, initiated 07/11/25. Resident #114's bed to be kept in lower position, initiated 07/11/25. If Resident #114 has increased restlessness in bed at night, staff to get them out of bed in recliner chair in view of staff at the nursing station, initiated 07/14/25. An additional review of the CP included a focus area initiated 07/11/25, for altered mental status with declining in functional status and progressive dementia. [Resident #114] has period of restlessness and agitation. Confusion leads to agitation. The goal was for Resident #114 to have less episodes of agitation. The interventions were to anticipate Resident #114's needs; toileting needs, positioning, and pain. The following incidents were documented in the Progress Notes: The surveyor reviewed the medical record which revealed that Resident #114 had four falls from 07/10/25 through 10/25/25, that were documented in the Progress Notes. All four falls occurred in the resident's room between

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #s NJ 388773, NJ 2573609, NJ 2595473, NJ 263559, NJ 2591993Based on observation, interview and record review, it was determined that the facility failed to ensure that sufficient staff were available at all times to ensure residents maintained their highest practical physical and mental well-being by failing to ensure: a) residents were provided with timely incontinence care for 2 of 2 residents reviewed (Resident #81 and #135), b) medications were administered per standards of practice (Resident #121) , c) adequate staff were available to clean up resident excrement in a timely manner, and d) the mandatory New Jersey staffing requirements were consistently adhered to. The deficient practice had the potential to affect all residents who resided on 3 of 3 units and was evidenced by the following: a. Resident #81:On 12/02/25 at 8:02 AM, the surveyor observed Resident #81 in bed. During an interview with the resident, they informed the surveyor that they had not received incontinence care nor had been repositioned since 9:30 PM last night, which was 10.5 hours prior.On 12/02/25 at 8:34 AM, the surveyor interviewed the resident's 7:00 AM to 3:00 PM assigned Certified Nurse Aide (CNA) who stated that the resident informed him that they had not seen a CNA last night. They resident stated they were leaning against the siderail for the entire night and staff did not come to the room when they activated the call light.On 12/02/25 at 8:35 AM, the surveyor performed an incontinence observation with the CNA assigned to the resident. Resident #81 was saturated with urine, and the bedding, including the pad were soaked with urine and were yellow stained. The CNA assigned to Resident #81 for the morning shift stated that he was not aware that the resident had not been changed. The CNA further stated he did not receive report from the 11:00 PM - 7:00 AM shift, and he repositioned the resident this morning but did not provide incontinence care. Resident #81 had was observed with some redness on the buttocks and groin areas; the skin was not opened. The CNA stated that the night shift staff was supposed to check and change the residents, prior to leaving at the end of their shift.Resident #135:On 12/2/25 at 8:06 AM, the surveyor observed Resident #135 in bed, their extremities appeared contracted (muscles and tending shorten/stiffen and often from prolonged immobility). Resident # 135 was positioned on the right side; their eyes were opened but Resident #135 was nonverbal and unable to communicate with the surveyor.The surveyor asked a random CNA to assist with an incontinence care tour observation, and two CNAs performed incontinence care. The surveyor observed that Resident #135 was saturated with urine. Resident #135 had a wound dressing on the left hip area that was also saturated with urine and bloody drainage. The CNAs repositioned the resident to the right side, and we all observed Resident #135 was wearing two incontinence briefs which were both saturated with urine. One of the CNA informed the surveyor that Resident #135 was on her assignment, but she did not provide any care yet. The CNA declined to comment when inquired if it was the first time, that Resident #135 was clothed with two incontinence briefs. On 12/05/25 at 8:40 AM, the surveyor interviewed the CNA who assisted the surveyor with the incontinence observation. The CNA stated that when the CNAs reported to their units, the CNAs should be checking the residents to ensure that everyone was safe and that incontinent residents were clean and dry. The CNA further stated that incontinence care should be provided at least twice during each shift to ensure that the residents were not soiled or if they needed to be assisted to the toilet prior to finishing their shift. The CNA added, Incontinent residents should never be wearing multiple briefs because that create moisture and could cause skin issues.On 12/5/25 at 10:30 AM, the surveyor reviewed Resident #135's admission Record which reflected that the resident had diagnoses which included, but were not limited to; cognitive communication deficit, unspecified dementia, osteomyelitis of vertebra, muscle weakness, and bed confinement status.On 12/02/25 at 12:05 PM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM). The LPN/UM stated that incontinence care was to be offered every two hours and as needed. The LPN/UM reviewed the schedule with the surveyor and stated that one CNA called out and there were only two CNAs for the floor, and each CNA had to care for 23 residents. The LPN/UM stated the Census was 47, and did not offer an option for other staff to assist if a CNA called outReview of the most recent quarterly MDS dated [DATE], indicated that Resident #135 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated the resident had severe cognitive impairment. A further review of the resident's MDS, Section GG - Functional Status indicated that the resident was totally dependent on staff for care.On 12/09/25 at 11:34 AM, the surveyor interviewed the CNA who cared for the resident on 11:00 PM-7:00 AM shift. The CNA confirmed that she placed two briefs on the resident. She also stated she cared for the

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review it was determined the facility failed to develop and implement an infection prevention and control program (IPCP) to limit the potential transmission of bacteria during a facility wide infestation of cockroaches, ensuring clean linens were protected from pests, and ensure water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems were developed and implemented.The deficient practice affected all residents who resided on 3 of 3 resident units and was evidenced by the following: Reference: Guidelines for Environmental Infection Control in Health- Care Facilities; Recommendations of CDC (Centers for Disease Control) and the Healthcare Infection Control Practices Advisory Committee; 2003; Updated July 2019. Refer to F584 and F925Fa. On 12/2/25, Surveyor #1 conducted an initial tour of the facility on the second floor, and observed the following:At 7:49 AM, a food cart was adjacent to the nursing station. The food cart contained left over and uncovered food items from the prior evening meal.At 8:05 AM, Surveyor #1 entered Resident #135's room with two Certified Nurse Aides (CNA's) to observe incontinence care. The bathroom floor was covered with various debris, which included used plastic bags, a broken toilet seat was also observed on the floor. While in the room with the CNAs the surveyor observed a brownish cockroach type bug crawling on the wall. Upon inquiry, the CNA's informed the surveyor that the facility had roaches.At 8:15 AM, the surveyor reviewed the pest control book that was located at the nurses' station and reviewed the pest control book. According to the data entered in the book, there was documentation regarding staff observations and cockroaches on the 2nd floor, and in resident's rooms dating back to 7/17/25. At 8:18 AM, the surveyor entered room [ROOM NUMBER] and observed a pile of soiled linen on the floor. At 8:20 AM, Resident #100's room had food debris, including straws and a red substance that was splattered on the floor. A CNA stated the red substance was food debris.On 12/2/25 at 8:45 AM, Surveyor #2, conducted an initial tour of the facility on the third floor and observed the following:On 12/04/25 at 9:49 AM, Surveyor #2 conducted a resident council meeting with four residents. Four of four residents stated that there were cockroaches in the facility and the residents stated they observed cockroaches in their bathroom, bedrooms, on the beds and 1 of 1 resident stated the cockroaches were inside of their closet. On 12/04/25 at 12:30 PM, Surveyor #2 and #4 observed Resident #31's room. Resident #31 allowed the surveyors to observe their closet for cockroaches. Upon opening the closet door, both surveyors observed swarming live cockroaches scatter, and many dead cockroaches were affixed to a white sticky trap. Personal belongings that included a blanket, computer and clothing were observed inside the closet with the swarming cockroaches. Upon interview, Resident #31 stated they were not offered to have their closet or clothing cleaned after the exterminator had placed the cockroach trap in the closet. On 12/04/2025 at 12:47 PM, Surveyor #4 interviewed the Registered Nurse Unit Manager (RNUM) of the 3rd floor and asked if there were cockroaches observed on the 3rd floor. The RNUM stated, yes and showed the surveyor the pest log where sightings were documented. A review of the pest logs revealed cockroaches were documented as observed on the 3rd floor beginning 6/1/24.On 12/04/2025 at 12:54 PM, Surveyor #4 interviewed the Licensed Practical Nurse Unit Manager (LPNUM) for the 4th floor. When asked if there were cockroaches observed on the 4th floor, the LPNUM stated, yes and showed the surveyor the pest log. A review of the pest logs revealed cockroaches were documented as observed beginning 7/16/25.On 12/05/2025 at 9:58 AM, Resident #31 informed Surveyor #2 that they had observed more cockroaches crawling on their floor during the night.On 12/05/25 at 12:25 PM, Surveyor #4 interviewed the Licensed Nursing Home Administrator (LNHA) regarding the cockroaches. The LNHA stated he started in the position on 8/26/25 and scheduled a meeting with the pest control company. Surveyor #4 asked the LNHA if he had observed cockroaches, and he stated yes, it is a problem.On 12/09/25 at 7:22 AM, Surveyor #1 observed a cockroach crawling on the clean linen cart that was in the 2nd floor hallway. The surveyor alerted the staff and the Housekeeping Director (HD) then removed the linen cart from the floor. On 12/09/25 at 9:10 AM, Surveyor #4 met with the Supervisor from the Pest Management (SPM) Company and the LNHA, in the presence of the survey team. The SPM stated the cockroaches were the German cockroaches, and were the dirty roaches, the worst to get rid of. Surveyor #4 asked if the German cockroaches transmitted disease and the SPM stated, they can. The surveyor asked the LNHA if it would be okay if the cockroaches crawled on linens and on resident personal belongings and clothing? The LNHA stated that was not okay, nobody wants cockroaches. The

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	315324	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trenton Gardens Rehabilitation and Nursing Center	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)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. (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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Complaint # NJ 2587050Based on observation, interview and review of pertinent documents it was determined that the facility failed to ensure the ice machines were maintained in a clean and sanitary manner, and per manufacturers' instructions. The deficient practice was identified for 3 of 3 ice machines located on the 2nd, 3rd and 4th floor resident units, and was evidenced by the following: On 12/2/25, Surveyor #1 conducted an initial tour of the facility on the second floor, and observed the following:At 7:36 AM, the ice machine located in the resident dining room, had a plastic type ice chute that was heavily soiled inside with white and black colored substances. The drain cover had a rust like build and the molding around the ice machine was peeling off.On 12/2/25 at 8:45 AM, Surveyor #2, conducted an initial tour of the facility on the third floor and observed the following:The ice machine located in the resident dining room had blackened areas inside the ice chute, and the area also had blackened discolored embedded areas where the ice chute attached to the machine and where a receptacle would be placed to catch the ice. The lower part of the ice machine also appeared soiled and stained in the drain area.On 12/2/25 at 7:30 AM, Surveyor #3 conducted an initial tour of the facility on the fourth floor and observed the following:The ice machine located in the dining room had blackened areas inside the ice chute and where the ice would be collected in a receptacle. The drain area on the ice machine had embedded blackened and white areas, and various spatter type debris was located on the exterior of the ice machine. On 12/2/25 at 1:30 PM, Surveyor #4 interviewed the Licensed Nursing Home Administrator (LNHA) and escorted the LNHA to observe the condition of the ice machines located in the 2nd, 3rd and 4th floor dining rooms. Surveyor #4 observed the finding as above in the presence of the LNHA. The LNHA confirmed the surveyor observations of all three ice machines and acknowledged the various debris observed inside the ice chutes and on the ice machines. The LNHA stated the ice machines would not be used due to the conditions of the machines and all three machines would be placed out of service until they are cleaned.On 12/5/25 at 8:46 AM, Surveyor #5 interviewed the Maintenance Director (MD) regarding the facility process for cleaning the ice machines located on the resident units, and asked how often the machines were cleaned? The MD responded that he did not know how often the ice machines were cleaned. Surveyor #5 asked the MD if there was a sticker, or document located at each ice machine to identify when it had been cleaned, and the MD stated he was not sure. The manual for the ice machines was also provided by the MD at that time. The MD was asked if he had cleaned the ice machines since he had been appointed the MD, and he responded he had not. Surveyor #5 asked the MD if he knew the steps for cleaning the ice machines and he responded, No, I think there are quite a few things that I do not know about here or know that they need to be completed. The MD stated, he will get it done.On 12/5/25 at 9:28 AM, the MD exited the tour and the LNHA continued the tour with Surveyor #5 and at that time Surveyor #5 observed the ice machine on the 2nd, 3rd and 4th floor were all turned off and placed out of service. Surveyor #5 observed a build up of a white substance at the ice chute area for all three ice machines. On 12/05/25 at 12:25 PM, Surveyor #4 interviewed the LNHA who stated he had been the LNHA since 8/26/25 and when asked the LNHA if he has seen cockroaches? The LNHA stated yes, it is a problem. The LNHA provided the Pest Management Service Inspection Report/Invoice book.The surveyor reviewed the Pest Management Service Inspection documents which revealed the following Service Inspection Report/Invoice dated 07/24/24. Under General Comments/Instructions: Check in with Maintenance. 2nd floor dining room and nurses' stations -roach activity 7/19 confirmed via phone. Treated second floor, nurses' station, pantry, and dining room area and kitchenette for roach activity . Observed minor activity near the ice machine. On 12/10/25 at 7:30 AM, Surveyor #2 toured the 4th floor and observed the ice machine in the dining room did not have an out of service sign on it. There was water on the countertop next to the machine, along with a wet towel in the water. The counter that the ice machine was located on had a box of paper place mats in a box, and the water was observed on the box of paper place mats. There were also ice cubes on the floor in front of the ice machine.On 12/10/25 at 10:39 AM, Surveyor #4 interviewed the MD who stated he was recently hired as MD, although has worked as Maintenance Assistant for a few years. When asked if he had ever been aware of cockroaches by the ice machine, he stated No. When asked if he had ever been instructed to clean the ice machines, he stated that after the surveyors brought the concerns with the soiled ice machines to the facility's attention, he cleaned them, and had to purchase the special chemicals to clean the ice machines since the chemicals were not available in the facility. When asked if the former MD, who he worked under, had educated him on the process to clean

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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. (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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # 388773Based on interviews, record reviews and reviews of other facility documentation, the facility failed to ensure that staff received behavioral health training to assist them in coping effectively with residents who had maladaptive behavior of being disruptive, cursing and spitting at staff. This deficient practice was identified for 1 of 2 residents reviewed for behavior, Resident #157, and was evidenced by the following:A review of a Facility Reportable Event Record (RER). dated 2/13/25 revealed a Narrative: Resident #157 picked up a piece of cake that the aide (Certified Nurse Aide) was going to give to another resident, and the aide explained that the cake was not for Resident #157, and took a bite out of the cake and spit it at the aide, and gestured to hit the aide, who then raised a hand to protect herself. Another aide was present when Resident #157 stated you hit me, the supervisor was called, the police and Crisis.On 12/5/25 at 10:00 AM, the surveyor reviewed the medical record for Resident # 157 revealed was admitted to the facility with diagnoses which included but were not limited to, other bipolar disorder, post-traumatic disorder, other frontotemporal neurocognitive disorder. The Discharge Minimum Data Set MDS dated [DATE] revealed that Resident #157 scored 15 out of 15 on the Brief Interview for Mental status, indicative of intact cognition. Section E of the MDS which addressed behavior was coded as Zero indicating absence of behavior.The Comprehensive Care Plan dated 9/13/24, had the following focus: Resident #157 continues to make false statements, allegations and accusations against others. Family has confirmed that Resident #157 paints himself as the victim usually after when they were caught from wrongdoing. Resident #157 recently had an altercation with another resident, they had no patience. They get easily frustrated with the staff and care received. Had long history of calling 911. They can be intrusive and not easily redirected. Initiated: 01/10/2025 and last revised on 02/13/2025. The goal was for Resident #157's behavior will remain stable X 90 days. Initiated: 09/13/2024 with a target date of 03/12/2025. One of the interventions was for staff (CNA, LPN, RN) to be calm and reassuring in all approaches. Initiated 09/13/24.The surveyor reviewed an allegation of abuse dated 2/12/25. Resident #157 alleged that the CNA hit them in their face. Resident #157 called 911 and their representative and reported the incident on 2/12/25.On 12/5/25 at 11:00 AM, the surveyor reviewed the investigation provided by the facility. According to the CNA's statement, Resident #157 went to the nursing station, saw a piece of cake on the counter, took the cake without asking and proceeded to eat the cake. The CNA entered the nursing station and observed the resident eating the cake and asked Resident #157 to return the cake. Resident #157 refused. The CNA reached out for the remaining of the cake and the resident got angry and started to be verbally abusive and spiting. The CNA stated she protected herself from being assaulted and spitting on.On 12/5/25 the surveyor attempted to interview the resident, but the resident no longer resided at the facility and could not be interviewed. The surveyor reviewed Resident #157's statement and the resident alleged that the CNA hit them in their face. There were no other staff at the nursing station who witnessed the incident. Staff indicated they heard the commotion but did not witness the incident.On 12/9/25 at 1:30 PM, the surveyor interviewed the CNA regarding the incident. The CNA stated, Resident #157 came at the nursing station and took a piece of cake that she wanted to give to another resident. The resident ate half of the cake. When she observed the resident with the cake, she asked the resident for the remaining of the cake. The resident refused. She reached out for the cake and placed her hand in front of the resident's mouth to prevent the resident from spitting on her clothing. The resident then stated that she hit them. The surveyor then asked the CNA if she could elaborate on the facility's protocol regarding how to approach difficult residents or residents with behavior. The CNA stated, I should not have place my hands in front of the resident's mouth. I should have walked away and let the resident eating the cake. The CNA informed the surveyor that she was suspended for her actions and today again she was informed of another investigation and could not return to work.On 12/10/25 at 1:50PM, the surveyor discussed the above concerns with the DON. The DON stated that she was not aware that the CNA placed their hands in front of the resident's mouth. The DON informed the surveyor that the CNA was suspended today again for an incident that happened two days ago.A review of the facility's assessment last updated 10/17/25, reflected that the facility provided services and care for residents with Mental health and Behavior. Under Specific Care or practices, the following were noted under Mental health and Behavior: Conditions and similar diagnosis causing psychiatric symptoms and behavior like Impaired Cognition, Mental Disorders, Depression, Bipolar Disorder, Schizophrenia Anxiety, Trauma Informed Care/ Post Traumatic