

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  02/06/2026
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 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>Based on observation, interview and document review, it was determined that the facility failed to ensure the dietary staff were competent to maintain the kitchen in a manner to ensure that appropriate sanitation measures were in place to prevent potential food borne illness or potential exposure from hazardous chemicals. This deficient practice had the potential to affect all residents and was evidenced by the following: On 2/5/26 at 8:10 AM, the surveyor toured the Second-floor nursing unit and observed that all the residents were being served their breakfast meal on disposable dishware with disposable utensils. During an interview with the Nurse on the floor at that time, she stated that that she could not comment why residents were eating on disposable ware and that the surveyor would have to ask the kitchen staff. On 2/5/26 at 8:20 AM, the surveyor toured the Third-floor nursing unit and observed the residents' breakfast meals were also being served on disposable dishware and utensils. The surveyor also noticed that regular meal trays with washable ware were being utilized for some residents. The surveyor also observed a meal cart with residents' used meal trays located in the hallway near the nursing station. Some of the meal trays contained regular ceramic type dishware and utensils and others had disposable items. On 2/5/26 between 8:30 AM and 9:42 AM, the surveyor toured the kitchen and inquired why the residents were being served on disposable dishware. The Cook, who was the Acting Food Service Director (FSD), informed the surveyor that the dish machine had not been functioning for one week and the facility had been using disposable dishware throughout the facility. The surveyor observed a rack which contained insulated burgundy colored bowls and cups. The [NAME] stated that those items were washed in the dish machine, although it was not functioning, but that the Licensed Nursing Home Administrator (LNHA) was aware. On 2/5/26 at 11:25 AM, the surveyor observed a Dietary Staff (DS #1) washing pans and pots in the three-compartment sink (a manual sink used in commercial kitchens to wash, rinse, and sanitize dishes). The surveyor observed DS #1 scraping off the food off the pots and pans, and then he washed the pots and pans in the first compartment sink, skipped the second compartment sink, and then submerged the pan and pots in the third compartment sink. DS #1 exited the kitchen before he could be interviewed. On 2/5/26 at 12:30 PM, the surveyor interviewed the LNHA and inquired if the New Jersey Department of Health (NJDOH) was informed that the dish machine had been out of service for one week. The LNHA stated, no he did not have to inform NJDOH as the dish machine was operating now as a low temperature dish machine. In the presence of the LNHA, the surveyor asked the [NAME] to run the dish machine. The [NAME] could not operate the dish machine. The LNHA could also not operate the dish machine. There were also no test strips to check that the chemical concentrations were adequate. The surveyor then asked for the log the facility used to monitor the function of the dish machine. The [NAME] could not locate the log. The [NAME] was unable to identify who checked the chemical sanitizer that morning. On 2/5/25 at 12:35 PM, the LNHA stated that the dish machine temperature did not need to be checked, and stated it is a low temperature machine. The surveyor asked him to check the chemical</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 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>concentration, and the LNHA could not locate the test strips. The surveyor then observed a clipboard on a metal shelf in the kitchen. The surveyor reviewed the dish machine log, and the last entry was recorded on 12/31/25. On 2/5/26 at 2:30 PM, the surveyor returned to the kitchen and observed DS #1 operating the three-compartment sink again. The surveyor asked DS #1 to explain the process to operate the three-compartment sink. DS #1 stated, I do not have to check anything. The surveyor then asked him to check the sanitizer in the third compartment sink. DS #1 could not check the sanitizer, there were no test strips available, and he then exited the kitchen. On 2/5/26 at 2:35 PM, the surveyor approached the [NAME] and inquired about the protocol for the three-compartment sink. The [NAME] was unable to provide a log and there were no test strips to check the sanitizer concentration. On 2/5/26 at 2:40 PM, the surveyor called the Dish Machine Vendor (DMV) and inquired about the work order for the dish machine. The DMV informed the surveyor that he was at the facility on 1/28/26, to check the dish machine. The DMV stated that the dish machine could not reach the required temperature because of the problem with the roof exhaust system; and the heat booster was not working. The DMV stated that he then set the machine to operate at a low temperature and with a chemical sanitizer. The DMV stated that he recommended that staff checked the chemical sanitizer regularly to ensure adequate sanitation. On 2/5/26 at 4:30 PM, the surveyor observed the DMV in the kitchen. The invoice provided confirmed that he worked on the dish machine on 1/28/26, and advised the dietary staff to check the sanitizer daily. The facility was unable to provide documentation that the sanitizer had been checked. On 2/6/26 at 8:00 AM, the surveyor entered the kitchen and observed the breakfast meal tray preparation was in progress and all disposable dishware was utilized and placed on non-disposable meal trays. The surveyor also observed that the non-disposable trays were in the three-compartment sink submerged in the sanitizer. At that time, the [NAME] was interviewed regarding the status of the dish machine. The [NAME] stated the dish machine was not being used and confirmed that the DMV came yesterday. The [NAME] stated when the DMV looked at the sanitizer that had been attached to the dish machine, and he informed the [NAME] that it to be appeared expired due to the faded color of the product. The [NAME] continued that the sanitizer was a chlorine-based sanitizing agent so it would lose its potency over time. The [NAME] stated the (heat) booster was still broken which was related to something on the roof and that the dish machine still needed to be delimed. The [NAME] stated that the DMV checked the chemical potency with the test strips, and she stated, it was not registering and the chemical was no good. The [NAME] stated that the DMV did not have another chemical sanitizer to provide the facility at that time. The [NAME] stated at that time, the LNHA instructed the [NAME] to stop using the dish machine. On 2/6/26 at 8:35 AM, the surveyor asked the [NAME] about the meal trays submerged into the sanitizer compartment of the three-compartment sink that the basin of the sink was not filled to the level of the sanitizer per the sticker affixed to the outside of the sink. The surveyor asked her to check the sanitizer solution for appropriate concentration. The [NAME] brought over two chlorine test strip containers and placed a strip into the sanitizer compartment, counted to fifteen, and removed the strip. The strip did not change color when she compared the strip to the corresponding colors on the package. When asked how long the test strip should be submerged, she stated fifteen seconds. The surveyor observed the chlorine strip package had 1 second, and not fifteen. The [NAME] stated, it is not registering, it is no good, and the concentration should be 200 (PPM- parts per million), and she was not familiar with the chemicals. At that time, the surveyor observed a poster affixed to the wall above the three-compartment sink titled Pot &amp; Pan Cleaning &amp; Sanitizing Procedures. The poster was in English and Spanish and revealed: Step 1. fill wash sink with hot water and with the detergent cleaner; 2. Pre-scrape pots and pans and soak for at least five</p> <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>burns. It causes respiratory tract irritation. Harmful if swallowed. Acute Effects: Eyes: Corrosive to eyes. Causes burns. Inflammation of the eye is characterized by redness watering and itching. Inhalation: may give off gas. Vapor or dust that is very irritating or corrosive to the respiratory system. Exposure can cause coughing, chest pain and difficulty in breathing. Ingestion: harmful if swallowed. May cause burns to mouth, throat and stomach. Ingestion may cause burns to mouth, throat and stomach. Ingestion may cause erosion of mucus membranes and perforation of the esophagus and stomach. A review of the Food Service Director Job Description revealed the following: The Food Service Director (FSD) will report to the Administrator. The FSD is responsible for planning, organizing, staffing, directing, coordinating reporting, budgeting, and physical management of the dietary department's employees and equipment in a way that the dietary services of the facility shall be maintained in accordance with established policies. The FSD is directly responsible to the Administrator. Inspect and supervise food preparation and service to ensure that infection control and the highest sanitation standards in all aspects of the dietary department are followed. NJAC 8:39-17.1 (a)</p>

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<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, interviews, record review, and review of facility policy, it was determine that the facility failed to ensure standard food safety practices were put in place to prevent food borne illness by ensuring a.) the dish machine and the three-compartment sink were maintained in safe operating conditions in accordance with manufacturer's specifications; b.) adherence to sanitary requirements to ensure all dishware was properly sanitized to prevent potential foodborne illness or potential exposure to hazardous chemicals; and c.) a monitoring system was in place and staff were competent to record the temperature and the chemical concentrations of the sanitizing agent. This deficient practice had the potential to affect all 185 residents. On 2/5/26, the surveyor observed breakfast meal trays on two resident nursing units that contained disposable dishware, as well as trays with regular wash ware. Interviews with dietary staff revealed that since 1/28/26, the facility's dish machine had not been operating at the appropriate temperature, so the facility was serving on disposable dishware and trays. The Cook, who was the Acting Food Service Director (FSD), stated that the facility was using disposable dishware for most of the residents, and the facility sanitized the cookware including pots, pans, and utensils in the three-compartment sink (a manual sink used in commercial kitchens to wash, rinse, and sanitize dishes). The surveyor also observed a rack of insulated bowls and cups that the [NAME] confirmed was sanitized by the dish machine. The [NAME] was unable to provide evidence that the dish machine was being checked daily for function, and the last recorded entry on the daily log was 12/31/25. The surveyor observed the Dietary Staff (DS #1) washing pots in the three-compartment sink, who stated he did not check the sanitizer prior to washing pots and pans, and there was no log provided that the sanitizer levels were being checked daily in the three-compartment sink. Interview with the Dish Machine Vendor (DMV) on 2/5/26, revealed that the facility's high temperature's dish machine's booster (aided in increasing hot water temperature) was not functioning properly, and he modified the dish machine to a low temperature dish machine to sanitize with a chemical solution. The DMV was on-site on 2/5/26, and he informed the facility that the chemical solution in the dish machine was expired and not properly sanitizing dishware. The facility's failure to ensure a process was in place for residents' dishware and the cookware used to prepare and serve meals were being properly sanitized in accordance with manufacturer's specifications and standards of food safety practice placed all residents at risk for food borne illness. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 2/5/26, when it was observed dishware and cookware including pots, pans, and utensils were not being properly sanitized. The facility was notified of the IJ on 2/5/26 at 6:20 PM. The facility submitted an acceptable Removal Plan (RP) on 2/6/26 at 12:05 PM. The surveyors verified the implementation of the Removal Plan during the continuation of the on-site survey on 2/6/26. The evidence was as follows:A review of the facility's policy titled, Dishwasher Temperature dated 5/10/24, last revised 6/12/24, revealed: It is the policy of the facility to ensure dishes and utensils are cleaned under sanitary conditions through adequate dishwasher temperatures.Policy Explanation and Compliance Guidelines:All items cleaned in the dishwasher will be washed in water that is sufficient to sanitize all items.Staff shall follow for machine washing and sanitizing instructions.For high temperature dishwashers (heat sanitization):The wash temperature shall be 150-165-degree Fahrenheit (F)The final rinse temperature shall be 180-degree F or above but not to exceed 194-degree F (165 degree F) for stationary rack, single temperature machine) Corrective actions shall be taken for final temperatures below the required final rinse temperatures.For low temperature dishwashers (chemical sanitization):The wash temperature shall be 120-degree FThe sanitizing solution shall be 50 parts per million</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>(ppm) hypochlorite (chlorine) on dish surface in final rinse. A review of the facility's policy titled, Dish machine Failure dated 6/22/24, revealed the following procedure: If dishwasher is out of service, the facility will utilize disposable products for meals until dishwasher is in proper working order. If temperature of dishwashing machine reads below 160 [degrees F] for wash/180 degrees [F] for rinse degrees restart the machine if then the temps are not sufficient notify your supervisor. The supervisor will notify Maintenance Department to address the problem.If Maintenance department cannot resolve the problem, Dietary Supervisor will notify the repair service.Until the dishwasher is repaired, meals will be served on disposable plates and plastic utensils/ paper cups plates will be covered with plastic wrap.Dietary Supervisor will notify each unit of the situation. There was no information in the policy regarding converting to a low temperature chemical sanitizer process if the heat booster failed. A review of the Safety Data Sheet for the Low temp Sanitizer that was attached to the dish machine and identified as the sanitizer solution, revealed the following:Signal Word: DangerHazard Statement: Causes eye and skin burns. It causes respiratory tract irritation. Harmful if swallowed.Acute Effects: Eyes: Corrosive to eyes. Causes burns. Inflammation of the eye is characterized by redness watering and itchingInhalation: may give off gas. Vapor or dust that is very irritating or corrosive to the respiratory system. Exposure can cause coughing, chest pain and difficulty in breathing.Ingestion: harmful if swallowed. May cause burns to mouth, throat and stomach. Ingestion may cause burns to mouth, throat and stomach. Ingestion may cause erosion of mucus membranes and perforation of the esophagus and stomach. A review of the Food Service Director Job Description revealed the following:The Food Service Director (FSD) will report to the Administrator.The FSD is responsible for planning, organizing, staffing, directing, coordinating reporting, budgeting, and physical management of the dietary department's employees and equipment in a way that the dietary services of the facility shall be maintained in accordance with established policies. The FSD is directly responsible to the Administrator.Inspect and supervise food preparation and service to ensure that infection control and the highest sanitation standards in all aspects of the dietary department are followed. On 2/5/26 at 8:10 AM, the surveyor toured the Second-floor nursing unit and observed that all the residents were being served their breakfast meal on disposable dishware with disposable utensils. During an interview with the nurse on the floor at that time, she stated that that she could not comment why residents were eating on disposable ware and that the surveyor would have to ask the kitchen staff. On 2/5/26 at 8:20 AM, the surveyor toured the Third-floor nursing unit and observed the residents' breakfast meals were also being served on disposable dishware and utensils. The surveyor also noticed that regular meal trays with washable ware were being utilized for some residents. The surveyor also observed a meal cart with residents' used meal trays located in the hallway near the nursing station. Some of the meal trays contained regular ceramic type dishware and utensils and others had disposable items. On 2/5/26 from 8:30 AM to 9:42 AM, the surveyor conducted an inspection of the kitchen and inquired why the residents were being served on disposable dishware. The observations and interviews revealed the following: The soap dispenser was not working, and a soap bottle was observed on top of the faucet. There were no paper towels nearby to dry hands after washing their hands. The [NAME] stated she was the Acting Food Service Director (FSD) while the FSD was out on leave. The [NAME] stated she had been made responsible for the operations of the kitchen as well as continuing to serve as the cook. The [NAME] stated that the dish machine had been out of service since last week due to the snowstorm, and that the dish machine did not meet the minimum temperature specification of 180 degrees F for the sanitizing agent. The [NAME] reported that the (heat) booster was not working. At that time, the surveyor observed a rack of insulated bowls and cups that had been</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>declined to comment. On 2/5/26 at 12:35 PM, the LNHA informed the surveyor that the dish machine temperature did not need to be checked and recorded. It is a low temperature machine. The LNHA did not comment that there were no test strips to check the temperature. The LNHA stated he could not recall the date he was made aware that the dish machine was not working, but he had called the vendor to service the dish machine at that time. The LNHA stated the vendor informed him and confirmed that the dish machine rinse temperature was not reaching the minimum required temperature for sanitation (180 degrees F), and that the dish machine could be utilized as a low temperature dish machine with chemical sanitizer. The LNHA stated that the dish machine had been running as a low temperature dish machine, however, he was unable to confirm when that occurred. The surveyor then asked the LNHA for the work invoice and the date that the work was completed by the vendor. According to the LNHA, the dish machine was operating at a low temperature and the staff were aware. The surveyor asked the LNHA if the New Jersey Department of Health (NJDOH) was made aware that the dish machine had not been working for a week, when they accepted 40 additional residents from an evacuated facility, and the LNHA stated that he did not have to inform the NJDOH since the dish machine had been running as a low temperature dish machine. The LNHA was not aware that the sanitizer also needed to be monitored with the low temperature setting, and neither the LNHA nor the dietary staff knew how to interpret the concentrations. The facility could not provide documentation that the sanitizer concentration had been checked and recorded on the log. The dietary staff were unable to demonstrate the procedure, set up the sanitizer solution, and measure the concentration. On 2/5/26 at 12:48 PM, the surveyor conducted an interview with the Director of Nursing (DON) regarding the dish machine. The DON informed the surveyor that she was informed on Friday night (1/30/26), that the dish machine was not functioning. The DON stated she purchased disposable dishware for the residents on Saturday morning and declined to comment further. The DON informed the surveyor that the LNHA was responsible for the kitchen, and she was not familiar with the operation of the dish machine. On 2/5/26 at 1:00 PM, the surveyor interviewed an unsampled resident who resided on the Third-Floor nursing unit. The unsampled resident informed the surveyor that last Sunday (2/1/26), the facility started using disposable ware. On 2/5/26 at 1:25 PM, the surveyor returned to the kitchen, and again interviewed the LNHA, who was also in the kitchen. The LNHA stated he was informed again at lunch time today, 2/5/26, that the dish machine was not working. The LNHA then informed the dietary staff to serve lunch on disposable dishware until the vendor could repair the dish machine. On 2/5/26 at 2:30 PM, the surveyor returned to the kitchen and observed DS #1 using the three-compartment sink. The surveyor asked DS #1 if he could demonstrate the process for using the three-compartment sink. DS #1 stated I don't check for anything. DS #1 was unable to explain the process and what the solution in each compartment should be. The surveyor then asked DS #1 to provide the log where the sanitizer concentration was recorded, and he could not provide the log and exited the kitchen. The surveyor then approached the [NAME] and inquired about the protocol for the three-compartment sink. The [NAME] could not locate the strips for the three-compartment sink to check the sanitizer concentration. There was no documented evidence that staff had been checking the sanitizer concentration. On 2/5/26 at approximately 2:40 PM, the surveyor contacted the Dish Machine Vendor (DMV) via telephone, who stated the hot water booster for the facility's dish machine was not working since the snowstorm. The DMV stated they could not resolve the issue with the (heat) booster, and he modified the dish machine to operate as a low temperature machine with the chemical sanitizer. The DMV stated he demonstrated and informed the staff at that time that the chemical needed to be checked daily. Upon inquiry, the DMV informed the surveyor the work on the dish machine was completed on 1/28/26, and he will forward the invoice today (2/5/26). A</p> <p>(continued on next page)</p>		

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  02/06/2026
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.			
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<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>review of the dish machine service Invoice dated 1/28/26, and provided by the facility revealed, The Booster is not working. The Booster is down due to weather blocking the ventilation for the exhaust. The Booster works on gas. Set up the dishwasher on chemical until booster is fixed. On 2/5/26 at 4:30 PM, the surveyor observed the DMV in the kitchen. The invoice confirmed that he completed work on the dish machine on 1/28/26, eight days prior, and informed the staff that the sanitizer for the dish machine needed to be checked daily. A review of the DMV's Invoice dated 2/5/26, provided by the LNHA revealed the following: Description of issue: Low temp chemical not reading. Work performed: Cleaned the spray nozzle of final rinse arms and changed the chemical bottle. It was reading the chemical when I left. Recommended to delime (deliming-prevents Operational Failure as limescale buildup can damage heating elements, pumps, and sensors, leading to machine failure and results in dirty dishes). On 2/6/26 at 8:00 AM, the surveyor entered the kitchen and observed the breakfast meal tray preparation was in progress and all disposable dishware was utilized and placed on non-disposable meal trays. The surveyor also observed that the non-disposable trays were in the three-compartment sink submerged in the sanitizer. At that time, the [NAME] was interviewed regarding the status of the dish machine. The [NAME] stated the dish machine was not being used and confirmed that the DMV came yesterday. The [NAME] stated when the DMV looked at the sanitizer that had was attached to the dish machine, and he informed the [NAME] that it to be appeared expired due to the faded color of the product. The [NAME] continued that the sanitizer was a chlorine-based sanitizing agent so it would lose its potency over time. The [NAME] stated the (heat) booster was still broken which was related to something on the roof and that the dish machine still needed to be delimed. The [NAME] stated that the DMV checked the chemical potency with the test strips, and she stated, it was not registering and the chemical was no good. The [NAME] stated that the DMV did not have another chemical sanitizer to provide the facility at that time. The [NAME] stated at that time, the LNHA instructed the [NAME] to stop using the dish machine. On 2/6/26 at 8:35 AM, the surveyor asked the [NAME] about the meal trays submerged into the sanitizer compartment of the three-compartment sink that the basin of the sink was not filled to the level of the sanitizer per the sticker affixed to the outside of the sink. The surveyor asked her to check the sanitizer solution for appropriate concentration. The [NAME] brought over two chlorine test strip containers and placed a strip into the sanitizer compartment, counted to fifteen, and removed the strip. The strip did not change color when she compared the strip to the corresponding colors on the package. When asked how long the test strip should be submerged, she stated fifteen seconds. The surveyor observed the chlorine strip package had 1 second, and not fifteen. The [NAME] stated, it is not registering, it is no good, and the concentration should be 200 (PPM- parts per million), and she was not familiar with the chemicals. At that time, the surveyor observed a poster affixed to the wall above the three-compartment sink titled Pot &amp; Pan Cleaning &amp; Sanitizing Procedures. The poster was in English and Spanish and revealed: Step 1. fill wash sink with hot water and with the detergent cleaner; 2. Pre-scrape pots and pans and soak for at least five minutes; 3. Scrub all surfaces; 4. Submerge in hot water rinse (2nd sink); 5. Submerge in sanitizer sink for 1-2 minutes. The instructions were to check the sanitizer solution, which was a quaternary solution, per the manufacturer's label and required a different type of test strip to confirm appropriate concentration which was 200-400 PPM. The surveyor brought the poster to the Cook's attention and inquired about the procedures. The [NAME] went to the office and retrieved an unopened package of a quaternary test paper, ripped off a piece, and tested the sanitizer which turned the indicator color between 200 PPM and 400 PPM. There was no thermometer to test the water temperature observed. When asked how long the strip was to be in the solution, the [NAME] stated 10 seconds, not 1 second. The</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Trenton Gardens Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  512 Union Street Trenton, NJ 08611	
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<p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>surveyor asked if the concentration has been documented, and the [NAME] stated, there was no log. When the [NAME] was asked what needed to be completed, she stated, we are going to have to Inservice. The surveyor requested any policies or procedures related to the three-compartment sink. The [NAME] stated that other than the poster, she was unaware of any other information related to the three-compartment sink. On 2/6/26 at 9:54 AM, the surveyor interviewed the LNHA regarding the dish machine. The LNHA stated that the machine was not yet delimed and the (heat) booster not functioning was related to a vent on the roof so the dish machine was not being used. The LNHA did not speak to the expired chemical. When asked if the staff had been educated on the process for the three-compartment sink, the LNHA stated that staff were instructed verbally, that they should dip it in (the strip) for 2-3 seconds and pull it out and the concentration should be documented on a log. The surveyor informed the LNHA of the observations above, and the affixed poster, and he said, he will check it out and he confirmed there were no competencies completed with the staff on 2/5/26. An acceptable Removal Plan (RP) was received on 2/6/26 at 12:05 PM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the immediacy including; on 2/5/26, the LNHA contacted the DMV. On 2/6/26, the LNHA the [Cook], dietary cooks and dietary aides regarding kitchen sanitation, to ensure proper handling of pots, pans, cutlery, and dishware. The LNHA re-educated the dietary staff on how to properly use the dish machine and the three-compartment sink to ensure washing, rinsing, and sanitizing was correctly done, in the correct order, with proper temperatures and sanitizing. The LNHA re-educated the dietary staff on the importance of documenting sanitizer tests results on flow sheets with each use. On 2/6/26 at 10:00 AM, return demonstrations/ competencies were completed by the pot washers and observed by the LNHA and interim FSD (the Cook). All dietary staff will be re-educated and required to complete competencies and return demonstrations prior to working. The LNHA re-educated the [Cook] and dietary staff regarding the use of disposables of paper goods in the event the dishwasher is out of service. All necessary dishware was immediately re-sanitized, and signs in English and Spanish with instructions for sanitizer use was posted by the dish machine and three-compartment sink. The survey team verified the implementation of the Removal Plan on-site and determined the immediacy was removed as of 2/6/26 of 2:12 PM. NJAC 8:39-17.2 (g)</p>		

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<p>F 0914</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide bedrooms that don't allow residents to see each other when privacy is needed.</p> <p>Based on observations and interviews on 2/5/26, in the presence of the facility's Licensed Nursing Home Administrator (LNHA), it was determined that the facility failed to provide privacy curtains in resident rooms to ensure each resident was afforded full visual privacy. This deficient practice had the potential to affect all eight residents who resided in the rooms (4 rooms). The deficient practice was evidenced by the following: On 2/5/26, between 9:00 AM to 10:45AM, the surveyor toured the 5th floor of the facility where eight out of 40 residents were transferred from another facility. In the presence of the Licensed Nursing Home Administrator (LNHA), the surveyor observed that there were no privacy curtains for residents in rooms 511A, 514A, 517A, and 519A. On 2/5/26 at 12:55 PM, the surveyor interviewed the LNHA and inquired why those residents did not have privacy curtains in their rooms. The LNHA stated the maintenance staff forgot to install privacy curtains in those rooms. The facility's Administrator was informed of the deficient practice at 3:28 PM during the Life Safety Code exit conference. A review of the policy titled Residents Rights provided by the LNHA revealed the following: Policy Statement Employees should treat all residents with kindness and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility; these rights include the residents' right to privacy and confidentiality. NJAC 8:39-31.2(e), 31.8 (c) 5</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, record review, and review of pertinent facility documents on 2/5/26, in the presence of the Maintenance Assistant, it was determined that the facility failed to ensure that residents were provided with direct communication system in which residents' calls were received and answered by staff. This deficient practice was identified for 2 of 40 residents reviewed (Resident #1 and Resident #2), and was evidenced by the following: According to the admission Record (AR), Resident #1 was transferred to the facility on 2/3/26 with diagnoses which included but were not limited to: Sciatica left side, Depression, Parkinson's disease and peripheral vascular disease. Resident #1 was dependent on staff for care. Resident #2 was transferred also to the facility on 2/3/26 and had diagnoses of bipolar disorder, hyperkalemia and generalized anxiety disorder. According to the Resident they required minimum assistance with care. On 2/5/26 around 10:10 AM, during the facility tour, Resident #1 asked Surveyor #1 to call the nurse. The surveyor asked the resident to activate the call bell. At that time the surveyor observed that the resident did not have a functioning call bell. On 2/5/26 at 10:30 AM, Surveyor #1 shared the above concern with Surveyor #2. On 2/5/26 at 10:45 AM both surveyors returned to the room and observed that the residents did not have a functioning call bell. On 2/5/26 at 10:50 AM, Surveyor #2 interviewed Resident #1 who stated that they were transferred from another facility on 2/3/26 and had not had a call device since the transfer. When inquired how they would call the staff, Resident #1 stated that the roommate would go to the hallway and call for assistance. Resident #2 shared the room with Resident #1. During an interview with surveyor #2, Resident #2 stated that she was able to manage mostly without assistance from staff. Resident #2 further stated that Resident #1 could not get out of bed and needed staff assistance. Resident #2 confirmed that she had to get out of bed and shouted for the staff to assist Resident #1. On 2/5/26 at 12:30 PM, the surveyor interviewed the Director of Nursing (DON) regarding the residents not having a functional call device. The DON informed the surveyor that she was aware that the call device in the room (room [ROOM NUMBER]) was not functioning. She audited the room for items that were needed prior to transfer and asked the supervisor to provide the residents with a manual call device. She was made aware only this morning after the surveyor's tour that neither was provided with a manual call device. A review of the facility's policy, titled, Call bell Use Responsibility dated 12/25 revealed the following: Purpose To ensure residents have timely access to assistance and that call bells are answered promptly to promote resident safety, dignity, and quality of care. Policy Statement All residents will always have access to a functioning call bell system. Staff must respond to call bells without unreasonable delay and in accordance with resident's assessed needs. Failure to ensure access or timely response may place residents at risk. NJAC 8:39-31.2(e), 31.8(c)9</p>		