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 04/17/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #2974086 Based on interviews, review of medical records, and review of other pertinent facility documents on 4/14/26, 4/16/26 and 4/17/26, it was determined that the facility failed to provide a safe environment and adequate supervision to prevent the elopement of a resident (Resident #3) who was identified as an elopement risk. Resident #3 eloped from the facility on 4/1/26, and was later found in the neighborhood near the facility by the local police. During the survey a finding that constituted an immediate Jeopardy (IJ) was identified under CFR 483.12(a) (1) for F689. The facility failed to implement interventions to maintain a safe environment with adequate supervision to prevent elopement.On 4/1/26, at approximately 3 PM, Resident #3's assigned nurse, Licensed Practical Nurse (LPN #1), observed the resident seated in a wheelchair in the main lobby, near the front door. LPN #1 stated during interview on 4/14/26, that she was aware that Resident #3 was an elopement risk, and that she did not approach the resident and and did not check for the resident's Safety Band (SB) on the resident's wheelchair. LPN #1 further stated that she left the facility and went home because it was the end of her shift. According to the Facility's Reportable Event (FRE) dated 4/2/26, on 4/1/26 at 3:15 PM during rounds, the 3-11 shift staff discovered that Resident #3 was not in their room and they initiated a search for the resident. The Director of Nursing (DON) and the police were notified of the missing resident (Resident #3) at approximately 3:20 PM. The Police located the resident on 4/1/26 at approximately 4 PM in the neighborhood near the facility and transported the resident to the hospital for evaluation.The facility's failure to provide a safe environment and adequate supervision to prevent Resident #3 from leaving the facility without staff knowledge, placed this resident as well as all residents at risk for elopement, at risk of likelihood of serious harm, injury, impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation.The IJ began on 4/1/26. The Licensed Nursing Home Administrator (LNHA) was informed of the F689 IJ and was provided with the IJ template on 4/16/26 at 5 PM. An acceptable Removal Plan (RP) was received on 4/17/26 at 11:36 AM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring.The surveyor verified the implementation of the RP during the continuation of the on-site survey on 4/17/26 and determined the immediacy was removed as of 4/2/26. The deficient practice was identified for 1 of 3 residents (Resident #3) reviewed and was evidenced by the following:The facility policy titled: Policy and Procedure Resident Elopement, with a reviewed date of June 2025, under Definitions, revealed that Elopement is defined as when a resident leaves the facility without their knowledge. The policy further revealed that after an elopement attempt, care plans would be updated and interventions that were established by the interdisciplinary team would be implemented. The facility policy titled: Policy and Procedure [Safety Band], with a revised date of June 2025, under Purpose, revealed that the placement of a Safety Band (SB) would aide in elopement prevention. The policy further revealed that the names of all residents at risk for elopement would be kept in a log, along with their picture, at the front desk. The policy also revealed that if a resident wearing a SB attempted to leave the facility, the alarm would be activated. A review of the Facility Reportable Event (FRE) dated 4/2/26, which the facility submitted to the New Jersey Department of Health (NJDOH), revealed that at approximately (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3:15 PM on 4/1/26, the 3-11 shift staff determined that Resident #3 was not in their room. The facility then initiated a search for the resident and notified the local police department. The FRE further revealed that police officers (PO) arrived at the facility at 4:15 PM with Resident #3 and then transported the resident to the hospital for evaluation. A review of the document titled: Incident Summary Report (IRS) dated 4/1/26, provided by the Director of Nursing (DON), revealed that Resident #3 was last seen by staff in the first floor lobby at approximately 3 PM. The IRS further revealed that according to hospital staff interview, the resident's Safety Band (SB) was not on the resident's wheelchair when the resident arrived at the hospital; and that the facility believed that Resident #3 removed their SB before they exited the facility. Resident #3 was not at the facility at the time of the survey. A closed record review was conducted as follows: According to the admission Record, Resident #3 was admitted to the facility with diagnoses which included but were not limited to: paranoid schizophrenia (subtype of schizophrenia characterized primarily by delusions and auditory hallucinations), schizoaffective disorder (a mental health condition that includes symptoms of both schizophrenia and mood disorders) and anxiety disorder. According to the comprehensive Minimum Data Set (MDS), an assessment tool dated 2/15/26, Resident #3 had a BIMs score of 7 out of 15, which indicated that the resident's cognition was severely impaired. A review of Resident #3's Elopement assessment dated [DATE] at 2:41 PM, indicated that Resident #3, .becomes impatient when waiting to be picked up by responsible party and will self-propel [themself] towards door, has exit seeking behavior at times. A review of Resident #3's Progress Notes (PN) revealed a nursing note dated 3/31/26 at 1:33 PM, written by Licensed Practical Nurse Unit Manager (LPN/UM), stated Resident observed to have potential to exit seek due to restlessness, poor impulse control, and impatience. Resident self-propelling towards door, resident expressing to go out front. [SB] placed on the back of resident's wheelchair, refused to have placed on wrist. A review of Resident #3's Order Summary Report revealed that an order was initiated on 3/31/26 for an SB to be placed on the back of the resident's wheelchair and that staff were to check for placement every shift. A review of Resident #3's Treatment Administration Record (TAR) for April 2026 revealed that Licensed Practical Nurse (LPN #1) signed that the SB was checked for placement on the back of the resident's wheelchair on the 4/1/26 day shift. A review of Resident #3's Care Plan (CP) revealed a focus initiated on 3/31/26, indicating that Resident #3 was an elopement risk, .related to impatience, and poor safety awareness, impulsive behavior, becomes impatient and has potential to self-propel [themself] in wheelchair out the door . The CP further revealed that Resident #3 had a SB placed on their wheelchair and that staff were to monitor the resident's whereabouts. An interview was conducted on 4/14/26 at 11:55 AM with Licensed Practical Nurse (LPN #1), who confirmed she was assigned to Resident #3 on the 4/1/26 on the 7 AM - 3 PM day shift. She stated that she was aware of Resident #3's elopement risk and that she checked the SB to be in place on the back of the resident's wheelchair on 4/1/26. LPN #1 further stated that interventions included monitoring and redirecting Resident #3 when exit seeking behaviors were observed. LPN #1 stated that when she observed Resident #3 in the lobby at 3 PM, she did not approach the resident and did not notify other staff members that the resident was in the lobby near the front door entrance. LPN #1 denied seeing the SB on the resident's wheelchair, and stated that the SB alarm system was not sounding when Resident #3 was in the lobby near the front entrance door. An interview was conducted on 4/14/26 at 12:39 PM with the Receptionist who stated that she worked at the Front Desk on 4/1/26 from 8 AM - 4 PM. She stated that she was trained on the Elopement Book (EB) and the SB system. The Receptionist stated that the EB had names and photos of all residents that were elopement risks. Receptionist further stated that she was to observe for wandering residents near the exits and report concerns immediately. She further stated that the purpose of the photos was to provide staff with a reference of which residents were at risk of eloping. Receptionist denied seeing Resident #3 in the lobby at 3 PM on 4/1/26, and stated she did not hear the SB alarm system sound. An interview was conducted on 4/14/26 at 2:09 PM with LPN/UM who stated that on 3/31/26, she assessed Resident (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#3 to be an elopement risk and placed an SB as preventative measure. LPN/UM stated when Resident #3 was located by the police and sent to the hospital for an evaluation, she contacted the hospital staff, and that when she inquired if Resident #3's SB was on the wheelchair, the hospital staff stated that there was no SB on the wheelchair. An interview was conducted on 4/14/26 at 2:51 PM with the Maintenance Director (MD). He stated that the SB system was tested weekly by his staff and that the last test prior to the elopement incident was done on 3/27/26 and there were no issues identified with the system. He further stated that a re-test was conducted on 4/1/26, after the elopement incident and no issues were identified with the SB system. An interview was conducted on 4/14/26 at 3:07 PM with the DON and the Licensed Nursing Home Administrator (LNHA). The LNHA stated that there was no camera footage available for review of the 4/1/26 incident. The DON stated that she was informed that Resident #3 was missing when she received a phone call from the Assistant Director of Nursing (ADON), and that by 4 PM she was informed that the resident was located by the police. The DON stated that a team meeting was held on the morning of 4/2/26 to review information provided to the team by the facility's staff which revealed that Resident #3's SB was not on the wheelchair when the resident arrived at the hospital. The DON stated that the team concluded that Resident #3's SB must have been removed prior to exiting the facility. An acceptable Removal Plan (RP) was received on 4/17/26 at 11:36 AM, indicating the action the facility would take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice, including:-Resident #3 had not returned to the facility.-On 4/1/26 the Maintenance Director tested exit doors that had SB antennas, including sensitivity ranges, and ensured that they were in proper working order.-On 4/2/26 the ADON conducted an audit of all residents wearing SB and confirmed that SB were in place and functional. The Staff Educator and the ADON initiated in-services to facility staff on SB and Elopement Policy and Procedures. Receptionists also received an in-service on Front Desk Responsibilities.-On 4/2/26, the DON implemented that going forward, to reduce the front door/lobby traffic, staff were now to use the side entrance to enter/exit the building. A sign was posted by the lobby door notifying all staff of the new entry/exit protocol. Staff Educator also initiated in-services for staff on the new side door entry/exit protocol.The surveyor verified the implementation of the Removal Plan on-site on 4/17/2026, and determined the immediacy was removed as of 4/2/26. NJAC 8:39-27.1 (a)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** COMPLAINT #297096, 2971506, & 2980872 Based on interviews, review of medical records and other pertinent facility documentation on 4/15/26, 4/16/26, and 4/17/26, it was determined that the facility failed to maintain accurate and complete medical record in accordance with acceptable professional standards of practice when staff failed to: a) consistently document toileting and bowel & bladder elimination in the Documentation Survey Report v2 (DSR) (Resident #4 and Resident #9) and b) provide documentation that a resident's request for a specific roommate was addressed (Resident #6).This deficient practice was identified for 3 residents of 9 reviewed (Resident #4, Resident #6, & Resident #9) and was evidenced by the following:a). A review of the admission Record revealed that Resident #4 was admitted to the facility with diagnoses that included but were not limited to: osteoarthritis (a degenerative joint disease where joint tissues break down over time), morbid obesity, and rhabdomyolysis (the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood).Review of Resident #4's comprehensive Assessment Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, dated 1/24/26, indicated that Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15; indicating that the resident's cognition was intact. Further review of the MDS revealed that the resident required, Substantial/Maximal assistance with toileting hygiene. The MDS also indicated that the resident was always incontinent of bowel and bladder.A review of Resident #4's care plan (CP) indicated that Resident #4 required four to six people assistance with bed mobility, and required use of a medical lift for all transfers. The CP stated that the resident was always incontinent of bowel and bladder.A review of Resident #4's Documentation Survey Report v2 (DSR) for April 2026 included care areas and times for staff to document on Resident #4's care. There was no evidence of documentation on the following dates and shifts:-Bowel and Bladder Elimination:4/4 Day, Evening, & Night4/5 Evening4/6 Evening4/7 Evening4/9 Day4/10 Day4/11 Evening -Toilet Transfer:4/4 Day, Evening, & Night4/5 Evening4/6 Evening4/7 Evening4/10 Day4/11 Evening -Toilet Hygiene:4/4 Day, Evening, & Night4/5 Evening4/6 Evening4/7 Evening4/9 Day4/10 Day4/11 Evening A review of the admission Record revealed that Resident #9 was admitted to the facility with diagnoses that included but were not limited to: heart failure, rheumatoid arthritis, cachexia (a wasting syndrome that leads to weakness, fatigue, and loss of skeletal muscle and fat).Review of Resident #9's comprehensive MDS an assessment tool used to facilitate the management of care, dated 2/16/26, indicated that Resident #9 had a BIMS score of 14 out of 15 indicating that the resident's cognition was intact. Further review of the MDS revealed that the resident required, partial/moderate assistance with toileting hygiene and transfer. The MDS also indicated that the resident was occasionally incontinent of bowel and frequently incontinent of bladder.A review of Resident #9's CP indicated that staff were to monitor and assist Resident #9 with transferring to the toilet and toilet hygiene.A review of Resident #9's DSR for April 2026 included that the following should be documented during each shift. There was no evidence of documentation on the following dates and shifts:-Bowel and Bladder Elimination:4/1 Day & Night4/2 Day & Night4/3 Day & Night4/4 Day & Night4/5 Day & Night4/6 Day & Night4/7 Day & Night4/8 Day -Toilet Transfer:4/1 Day & Night4/2 Day & Night4/3 Day & Night4/4 Day & Night4/5 Day & Night4/6 Day & Night4/7 Day & Night4/8 Day -Toilet Hygiene:4/1 Day & Night4/2 Day & Night4/3 Day & Night4/4 Day & Night4/5 Day & Night4/6 Day & Night4/7 Day & Night4/8 Day During an interview on 4/16/26 at 10:31 AM, Certified Nursing Assistant (CNA #1) stated that incontinent rounds were to be completed every two hours, and the purpose was to prevent skin breakdown. She stated CNAs were primarily responsible for providing the care and that all care provided was to be documented in the resident's electronic medical record (EMR), in order to keep all team members informed of the care provided. She stated that there should be no blanks but that there were times (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when care was provided and they forget to document. During an interview on 4/17/26 at 10:04 AM, Licensed Practical Nurse (LPN #2) stated that CNAs were responsible for providing and documenting all incontinent care in each resident's EMR. She stated that incontinent rounds were important to prevent skin breakdown. She further stated that all care should be documented because that is confirmation that care was provided. During a joint interview on 4/17/26 at 3 PM, with the Licensed Nursing Home Administrator (LNHA) and the Regional Nurse Consultant (RNC), the RNC stated that CNAs were primarily responsible documenting incontinent care in the EMR. She stated that documentation was important because it confirmed that care was provided. In the presence of surveyor, they reviewed the aforementioned DSR forms for Resident #4 & Resident #9. The RNC stated that there should not be any blanks on the forms and that Unit Managers were primarily responsible for ensuring that CNAs were documenting as they should be. She stated she was not sure what happened in these cases. b). A review of the admission Record revealed that Resident #6 was admitted to the facility with diagnoses that included but were not limited to: chronic kidney disease, depressive disorder.Review of Resident #6's comprehensive MDS, dated [DATE], indicated that Resident #6 had a BIMS score of 14 out of 15 indicating that the resident's cognition was intact.A review of Resident #6's CP indicated that the resident had a special relationship with another resident that was initiated on 2/6/26.A review of Resident #6's EMR did not reveal any documentation related to a request to have a specific roommate.The facility reported that there were no grievances on file for this resident. During an interview on 4/16/26 at 11:13 AM, Resident #6 stated that they would feel more comfortable if they had the roommate of their choice (Resident #5) and not liking that they could not be together. When asked if Resident #6 had expressed this concern to facility staff, the resident could not recall specific names but stated that they had and they still were not roommates. During an interview on 4/17/26 at 10:19 AM, Licensed Practical Nurse/Unit Manager (LPN/UM #2) stated that around the time of Resident #6's admission it came to her attention that Resident #5 and Resident #6 wanted to be roommates. She stated that all room change requests are referred to the social worker and that this is what she did in this case. She stated that she was aware that Resident #6's CP had been updated and that the residents spend time together regularly but that she was not sure why the rooms had not been changed. During an interview on 4/17/26 at 11:00 AM, the Director of Social Work (DSW) stated that she was familiar with Resident #6 expressing wanting to be roommates with Resident #5. She stated she was aware that Resident #6's cognition was intact and that the resident was able to make their own decisions. The DSW stated that the interdisciplinary team (IDT) met, developed a plan that they thought would ensure safety for both residents, and that Resident #6 had agreed with the plan. She stated that after the meeting, Resident #6's CP was updated to include the agreed upon interventions. When asked if there was any documentation that the resident agreed with the plan, the DSW stated that they did not document it but that they should have. During an interview on 4/17/26 at 1:40 PM, the LNHA stated being familiar with Resident #6's roommate request but that he was unsure of who told him. He stated that he, along with the DSW, participated in an individual meeting with Resident #6 to discuss the matter further. He further stated that after that meeting was held he participated in an IDT meeting and that they discussed that resident safety remained their primary goal. He stated that an an alternate plan was developed that included that the residents could spend time together. The LNHA stated that Resident #6 agreed with the plan that was developed and the care plan was updated and implemented. The surveyor requested evidence of documentation that the meeting occurred and that Resident #6 agreed with the plan and explained that none had been provided. The LNHA stated that the team meeting should have been documented so that everyone was aware that the request was addressed. A review of the facility's Policy and Procedure [Activities of Daily Living], dated December 2025, revealed that toileting and continent care were part of the facility's basic self-care tasks. It further revealed that CNAs were to document, in real time in the EMR and that documentation was to include the level of assistance the resident required the resident's response to the care, and/or if the resident refused. A review of the facility's P&P (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident Room Change policy, dated October 2025, revealed that the purpose of the policy was to, Ensure that all resident rights under law are adhered to. The policy further revealed that the social worker would address any resident requests for room changes. N.J.A.C. 8:39-27.1(a)