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 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 # 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; (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	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 4:43 PM and 12:38 AM. The most recent incidents were as follows: A nursing Progress Note dated 07/11/25 at 11:49 PM, revealed Resident #114 sustained a fall in their room. The resident was unable to provide any explanation regarding the fall. Resident #114 was transferred to bed with three-persons assistance, and the resident remained restless. A review of the nursing Progress Note dated 07/13/25 at 4:43 PM, revealed that Resident #114 was found on the floor of their room by a Certified Nursing Aide (CNA). The resident stated they were trying to get someone. Resident #114 reported back and hip pain, and an ordered x-ray was negative for fracture. A Post Fall Risk Assessment was completed, and the resident scored a 75 (high risk). After the fall on 7/13/25, the CP was revised, and the intervention to have Resident #114 out of bed and placed in the recliner chair at the nursing station during the night if the resident was restless was initiated on 07/14/25. A nursing Progress Note dated 07/20/25 at 12:38 AM, revealed Resident #114 sustained a fall in their room which resulted in a hematoma (collection of blood that gathers outside of blood vessels, forming a lump or mass) and abrasions to the back of their head. A Fall Risk Assessment was completed, and the resident scored a 75 (high risk). A nursing Progress Note dated 08/20/25 at 7:49 PM, that Resident #114 was found on the floor in the room in front of the television stand. The resident had blood on their clothes, and upon assessment, two skin tears were observed to their left elbow and one skin tear to their upper back. The resident denied discomfort or hitting their head. A Psychiatrist Consultation dated 08/22/25, after the fall, reflected the following: In light of [the resident's] current symptoms and behavioral profile, [the resident's] Ativan (anti-anxiety medication) regimen was adjusted from 2 [milligrams (mg)] at bedtime to 1 mg three times daily. The patient and family agreed with the plan, and the case was reviewed with nursing and unit leadership to support continued monitoring and structured care. A nursing Progress Note dated 10/25/25 at 11:00 PM, revealed Resident #114 was found on the floor in their room, and sustained two skin tears to the back. A Fall Risk Assessment was completed, and the resident scored a 65 (high risk). A nursing Progress Note indicated on 11/18/25, at approximately 8:00 AM, during morning care, Resident #114 was observed in bed guarding their left arm and grimacing upon touching their left arm. The physician was notified and ordered an x-ray of the left arm that was positive for an acute non-displaced left clavicle fracture. The recommendation was an orthopedic evaluation and transfer to the emergency room (ER) for further management and potential intervention. Resident #114 was transferred to the ER on [DATE] at 9:45 PM, and returned on 11/19/25 at 2:27 AM. Upon return, Resident #114 was complaining of pain and medicated with Ibuprofen 800 mg (non-steroid analgesic). A skin assessment was done upon return from the ER which revealed redness to left side of the resident's neck and shoulder. On 12/05/25 at 11:50 AM, the surveyor reviewed the facility investigation provided by the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Nursing (DON) dated 11/17/25, along with statements from all the caregivers who cared for the resident from 11/17/25 to 11/18/25. The investigation included a Reportable Event Record (RER) with a date of event 11/18/25 at 9:45 PM. The facility coded the incident as a Significant Event with an injury and the narrative revealed: during morning care, the aide noted the resident had discomfort in their left shoulder. The aide was able to wash and dress the resident, but the discomfort was a new finding by the nurse aide from the previous day. The aide reported it to the nurse and the clinical manager. The Registered Nurse assessed Resident #114 and there was no bruising or edema at site, but discomfort when touched. The physician was called and an order for Motrin (an anti-inflammatory) was ordered and provided. An x-ray was ordered, completed and reported as a fracture to the left clavicle non-displaced. The resident was sent to the emergency room and fracture was confirmed. The resident was returned to the facility with recommendations for a sling. Upon return an investigation was initiated. The statements attached to the investigation included the following: A statement from the Certified Nurse Aide (CNA #3) who worked the 11:00 PM-7:00 AM (11-7) shift on 11/17/25, documented that Resident #114 was restless for periods of time during my shift. I also seen them reaching and turning with their left arm. They were lying on their left arm for periods of time as well as also turns all ways in bed as they do in their chair. [Resident #114] did not yell or make any faces like they were in pain, and I confronted [Resident #114], and they eventually went to sleep. The Licensed Practical Nurse (LPN #1) who was assigned to Resident #114 during the 11-7 shift documented: Received [Resident #114] in bed, awake, talking out loud to self. No complaints of pain/discomfort observed or verbalized. Incontinence care rendered which consisted of resident having to be turned on right and left side. No issues reported or observed by CNA. Medication administered with no issues observed by this nurse. A telephone interview with LPN #2 that was documented by the Registered Nurse/Unit Manager (RN/UM) revealed that LPN #2 worked the 3:00 PM to 11:00 PM (3-11) shift on 11/17/25, and cared for Resident #114. LPN #2 stated resident was asleep at 10:00 PM. All medications were taken without difficulty. Very talkative and was in recliner chair in front of nursing station prior to bedtime. The Registered Nurse (RN #1) documented a statement dated the 11/18/25, incident that revealed the floor nurse informed her that Resident #114 was grimacing upon touching the left shoulder. Upon assessment, the resident verbalized pain upon touch. There was no redness, no bruise, no swelling. There was limited left upper extremity range of motion, and the resident was guarding their left shoulder. A STAT (immediate) x-ray was ordered by the physician. The Incident Summation Report revealed an Investigation and Conclusion: The 11/18/25, routine CNA reported a change to Resident #114, and it was determined that the injury occurred on the 11-7 shift on 11/17/25. CNA #3 reported that the resident had some periods of restlessness as also reported by the 3-11 shift while the resident was in the recliner, and although not new behavior, it did seem more pronounced. On 12/09/25 at 8:34 AM, the surveyor interviewed the RN/UM regarding Resident #114's care. The RN/UM stated that Resident #114 was confused, could stand and pivot, and always required assistance with care (extensive to dependent assistance). The RN/UM stated the resident was admitted to the facility with a diagnosis of dementia and could not execute any transfer without staff assistance. On 12/09/25 at 9:54 AM, the surveyor interviewed CNA #1, who was assigned to Resident #114 during the 7:00 AM to 3:00 PM (7-3) shift on 11/17/25. CNA #1 stated she provided care to the resident and brought the resident to the nursing station based on their plan of care. CNA #1 added that the resident was placed at the nursing station to prevent falls. On 12/09/25 at 10:15 AM, the surveyor conducted an interview with CNA #2, who was assigned to the resident during the 3-11 shift on 11/17/25. CNA #2 stated the resident was calm and did not display any signs of agitation during that shift. CNA #2 stated she transferred Resident #114 to bed with the 3-11 nurse at 9:00 PM, and she made her last rounds at 11:00 PM, and the resident was resting. On 12/09/25 at 10:35 AM, the surveyor interviewed CNA #3, who cared for Resident #114 during the 11:00 PM to 7:00 AM (11-7) shift on 11/17/25 (through 11/18/25). CNA #3 stated that Resident #114 was restless from the beginning of her shift (approximately 11:00 PM), when she made (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	her first rounds, until 4:00 AM. The surveyor asked her how she handled the resident's behavior during the night, and CNA #3 stated that she kept going to the room to check on the resident. CNA #3 stated that she informed the night nurse of the behavior, and the behavior was entered on the plan of care. The surveyor then asked CNA #3 to provide the documentation on the plan of care where the behavior was documented, and she could not access or provide the documentation. On 12/09/25 at 11:05 AM, the surveyor then interviewed CNA #3 in the presence of the RN/UM, and CNA #3 restated that Resident #114 was restless from the beginning of the shift, (11:00 PM) until 4:00 AM, and that she reported it to the nurse. CNA #3 stated, any change in behavior must be documented. The RN/UM asked CNA #3 where she entered the documentation, and she stated in the plan of care. The RN/UM at that time stated that the behavior could not be documented in the plan of care. CNA # 3 changed her story and stated that the nurse documented the behavior. At that time, the surveyor reviewed the progress notes with the RN/UM, and they were unable to identify where the behavior was documented. The surveyor also reviewed the 24 hour report with the RN/UM and there was no documentation which reflected that Resident #114 was restless until 4:00 AM in the morning. The surveyor then asked CNA #3 if she was aware that the resident was to be transferred into the recliner chair and placed at the nursing station if they were restless at night. CNA #3 stated yes, but sometimes the resident refused to get out of the bed. In the presence of the RN/UM, the surveyor asked CNA #3 if Resident #114 refused to be transferred out of the bed into the recliner chair on 11/17/25, during the night shift when the resident displayed restless behaviors, and CNA #3 stated, No. On 12/09/25 at 3:56 PM, the surveyor interviewed LPN #1 who worked on 11/17/25, during the 11-7 shift. LPN #1 confirmed that the resident was awake during her first rounding at 11:00 PM, and did not report any pain. LPN #1 stated she medicated the resident at 6:00 AM, with Ativan 1 mg and Resident #114 was not in any distress. LPN #1 denied that CNA #3 informed her that the resident was restless all shift until 4:00 AM, as stated by CNA #3 twice. When asked what should have been done for the resident if they were restless during the night shift, LPN #1 stated there was an intervention on the care plan to transfer the resident into to the recliner chair and place them in staff's view at the nursing station. LPN #1 stated that Resident #114 was a high fall risk, and if she was made aware, she would have gone to the room, assessed the resident, attempted to calm them, and called the physician to request if the resident could be offered the 6:00 AM dose of Ativan earlier. On 12/10/2025 at 10:44 AM, the surveyor re-interviewed the RN/UM regarding the interviews conducted with both CNA #3 and LPN #1. The RN/UM stated that the 3-11 nurse (LPN #1) was very credible. The RN/UM stated if the resident was restless until 4:00 AM, CNA #3 should have transferred the resident into the recliner chair and placed the resident at the nursing station for supervision. The RN/UM added, When [Resident #114] was at the nursing station, they were much calmer, they loved to interact with the staff at the nursing station. On 12/10/25 at 11:35 AM, the surveyor discussed the above concerns with the DON and inquired about the investigation. The DON stated that she interviewed CNA #3, who stated that the resident was restless, and she was able to comfort the resident. The DON further stated that she was not aware that Resident #114 was restless until 4:00 AM. The DON stated that CNA #3 should have followed the care plan which was to transfer the resident into the recliner chair and place the resident at the nursing station where the resident could be closely monitored. A review of the summary of the investigation included the following: the Interdisciplinary team met and reviewed the incident. There was no evidence of abuse or mistreatment. The resident's diagnosis of anxiety which presented with restlessness on the 11-7 shift; and their protein deficiency and their history of osteoporosis all played a role in this injury. Ongoing staff education on how to observe and report signs of resident changes, how to approach and calm residents with anxiety and how to reposition residents was given. NJAC: 8:39-27.1(a)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of pertinent facility documentation it was determined the facility failed to have a process in place to ensure that resident personal needs account (PNA) funds were available for distribution the same day as requested by the residents seven days per week. This deficient practice was identified for 3 of 3 residents (Resident #31, #40 and #130) who maintained PNA funds and attended a Resident Council (RC) group meeting.The deficient practice was evidenced by the following:Complaint #2595473On 12/04/25 at 11:04 AM, the surveyor conducted RC with four alert and oriented residents. During the RC meeting, three of three residents stated that they only had access to their money Monday through Friday, and every other weekend. All three residents confirmed there was only one staff member that had access to their PNA money, and she only worked every other weekend. During the weekdays the residents stated that the Activity Director (AD) distributed the PNA money when she was available. All three residents confirmed that there were no published hours when she was available, and she was hard to find.The surveyor reviewed the Electronic Medical Record (EMR) for Resident #31. A review of the resident's admission Record (AR) reflected that the resident was admitted to the facility with diagnoses which included but are not limited to Hypertension (HTN-high blood pressure) and Type 2 Diabetes Mellitus (DM-high blood sugar), Major depressive disorder and anxiety disorder.A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, dated 11/09/25, reflected a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the Resident had intact cognition. The surveyor reviewed the EMR for Resident #40. A review of the resident's AR reflected that the resident was admitted to the facility with diagnoses which included, but were not limited to; Hypertension (high blood pressure), Major depressive disorder (mental health condition), anxiety disorder (mental health condition) and Asthma (chronic condition that affects the airway).A review of the most recent quarterly MDS dated [DATE], reflected a BIMS score of 13 out of 15, which indicated an intact cognition. The surveyor reviewed the EMR for Resident #130. A review of the resident's AR reflected that the resident was initially admitted to the facility with diagnoses which included but not limited to: Malignant neoplasm of the prostate (prostate cancer), and Hypertension. A review of the most recent admission MDS dated [DATE], reflected a BIMS score of 14 out of 15, which indicated an intact cognition. On 12/04/25 at 10:00 AM, the surveyor interviewed the AD, who stated she was responsible for distributing the PNA funds to the residents Monday through Friday. She stated that PNA money was available seven days a week and the receptionists distributed the PNA money on the weekends.On 12/04/25 at 12:33 PM, the surveyor interviewed the Receptionist (R #1). She stated that she worked every other weekend, and she distributed PNA money on the weekends that she worked. R #1 stated that she worked the prior weekend, 11/29/25 & 11/30/25. She stated the receptionist (R #2) who worked the opposite weekend did not distribute the PNA funds because she was not trained. On 12/09/25 at 1:00 PM, R #1 informed the surveyor that after surveyor inquiry, R #2, was now being trained to distribute the PNA funds to the residents on the weekends she worked.On 12/10/25 at 1:10 PM, the surveyor interviewed R #2. She stated that she worked the opposite weekend of R #1. R #2 stated that she started working at the facility one month ago, and confirmed that she has not been trained regarding distributing PNA funds to the residents. She further stated, hopefully I will be trained next week.On 12/11/25 at 1:21 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON), Regional DON and the survey team. The LNHA acknowledged that the PNA was not available seven days per week. No further information was provided. A review of the facility's PNA receipts revealed that there were no receipts available for any resident withdrawals for all weekends in June, July and September 2025. The receipts provided by the AD for August, October and November 2025 had receipts for every other weekend (the weekend that R #1 worked). The facility was unable to provide any documentation that resident PNA funds were available for residents seven days per week. NJAC 8:39-4.1(a)10

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and review of pertinent facility provided documents it was determined that the facility failed to a) ensure that within 30 days of a resident's death, the resident's funds, and a final accounting of those funds were conveyed to the resident's responsible party for 2 of 2 expired residents reviewed (Resident #163 and Resident # 164) Personal Needs Account (PNA) accounts; and b) ensure the resident or resident's responsible party was notified that the funds in their PNA account reached the $2,000 maximum Supplemental Security Income (SSI) or $200 less of the maximum which could jeopardize their eligibility for SSI or Medicaid. This was identified for 5 of 5 (Resident #59, Resident # 68, Resident # 69, Resident # 101, Resident #136 and Resident #165) PNA accounts reviewed. The deficient practice was evidenced by the following:On [DATE] at 10:23 AM, the surveyor reviewed the residents' Funds Listing Report (Personal Needs Account-PNA) as of [DATE] and electronic medical records which revealed the following: -Resident #163's PNA reflected a PNA balance of $2,049.16, this resident had expired at the facility in February 2024 (22 months prior). -Resident #164 PNA reflected a balance of $2,548.15, this resident had expired at the facility in [DATE] (8 months prior). A further review of the facility provided PNA account of Resident Funds Listing Report, revealed four of the balances were over the $2,000 SSI maximum and two of the balances were over the $1,800 which was $200.00 less than the $2,000 maximum. The account balances were as follows:Resident #59 had an account balance of $2,240.44.Resident #69 had an account balance of $2,198.00.Resident #68 had an account balance of $1,908.86.Resident #101 had an account balance of $1,920.41.Resident #136 had an account balance of $2,102.56.Resident #165 had an account balance of $2,599.40.On [DATE] at 10:40 AM, the surveyor conducted a telephone interview, in the presence of the survey team, with the remote business office Biller about the PNA statements for the two expired residents with remaining PNA balances. The Biller stated when a resident expired the account should have been closed, and the following should have occurred. 1. The money should have been taken back from the state, or 2. The facility should have written a check to the State. The Biller stated she did not know why the check was not sent back to the State. The Biller stated it was my error I should have emailed the office to cut a check, and I did not do that, I messed up on that one. On [DATE] at 11:11 AM, the surveyor again interviewed the Biller regarding the PNA account balances for the current residents and asked what was the process to ensure that residents did not exceed their maximum amount which could jeopardize their ability to continue to participate in the Medicaid program. The Biller stated that she emailed the facility a list of residents who were accumulating PNA money, sometimes I'll let the Social Worker (SW) know. She stated that she has not recently emailed the SW, but she would inform them. She could not provide any documentation or verification that there was any communication between the facility to the residents or resident's representative of the accounts which could potentially jeopardize the Medicaid eligibility.On [DATE] at 12:13 PM, the surveyor interviewed the Director of Social Work #1 (SW #1) and Social Worker (SW #2) in the presence of the survey team. SW #1 stated if a resident had a concern with PNA we followed up with the Business office. We were only involved with PNA funds with the prior ownership and those accounts were managed by the in house business office. SW #1 and SW #2 stated that they had not received any any correspondence or emails from the business office for the past 3 months regarding the need to spend down resident's PNA so they are not in jeopardy of losing their Medicaid funds. Both confirmed they were not aware that Resident #59 was over resources. Both then acknowledged that Resident #59 needed a spend down (purchasing items the resident needed). SW #2 stated that Resident #59 had a Care Conference scheduled the next day,[DATE], and was not informed the resident had PNA that needed to be spent down for their needs. SW #1 stated the residents will get kicked off of Medicaid if they go over funds. Both stated they were not aware of any process to manage PNA funds. A review of the facility's Personal Needs Accounts policy last reviewed 4/2024, included; if the amount in the (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	account (plus the value of the resident's other non-exempt resources) reaches the SSI/Medicaid resource limit for one person, the resident may lose eligibility for Medicaid or SSI. No additional information was provided.NJAC 8:39-9.5

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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	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 surveyor asked what the follow-up had been with Resident #31's clothing and personal belongings after the surveyor informed him that the cockroaches were swarming in Resident #31's closet four days prior. The LNHA stated, it wasn't washed or anything. The SPM stated the clothes should be removed, bagged, and washed, because whatever is not treated, the bugs will come back. On 12/09/25 at 2:00 PM, Surveyor #4 in the presence of another surveyor, advised the LNHA of the above concerns regarding the environment and the need to extend the survey. On 12/09/25 at 4:12 PM, the Regional Director of Nursing (RDON), Director of Nursing (DON) and the LNHA met with the survey team. The RDON stated, we know that the pests are a problem, and we don't think what we have done has achieved the objective, even if we have to evacuate the building and we reached out to other vendors for another option. The LNHA stated we are going to take an aggressive approach. On 12/10/25 at 7:30 AM, Surveyor #2 observed the ice machine located in the 4th floor dining room had water surrounding it with a wet towel, and there was a box paper place mats saturated with water. There was ice cubes observed on the floor and on the counter. On 12/10/25 at 8:48 AM, Surveyor #2 interviewed an unsampled resident (UR) who resided on the third floor, The surveyor asked the resident if the resident observed cockroaches in the facility. The resident stated, I saw one yesterday, and when asked how they felt about the cockroaches, they stated it made them feel extremely angry, because if they are crawling on my face, then they are crawling on other people's faces. The resident stated they have seen cockroaches ever since they have been at the facility and stated they are a different kind of roach, much smaller. The resident further stated, I saw them coming up the wall, so I block my bed with towels to stop them from crawling on the wall onto my bed. The surveyor observed seven towels rolled up and placed on the long edge of the bed that was next to the wall. The resident stated, I do everything I can to keep them off of my face. On 12/10/25 at 10:32 AM, Surveyor #3 interviewed Resident #7 in their room while they were seated on the side of their bed. When asked if they had seen any pests like cockroaches in their room, they stated they see them and had been killing them. Resident #7 stated the facility had only treated certain rooms and not the whole floor. When asked how this made them feel Resident #7 stated terrible, and then stated, once, a while back my food was delivered and I took the top off, and a roach crawled out. Resident #7 stated the housekeepers don't clean very well and stated, I keep my room clean myself and showed the surveyor their personal broom and dustpan. The resident confirmed he had spoken to maintenance about the roach problem, but it didn't do any good, the problem had been going on for over a year. Resident #7 then stated a few weeks ago they had a roach crawling on him while in bed, and then they had to knock it off and then stepped on it. On 12/10/25 at 10:38 AM, Resident #12 was observed in their room seated on the side of his bed watching television. When asked if the resident had seen any pests like roaches in their room, they stated they had noticed roaches in their room. Resident #12 stated yesterday they saw a roach crawling on the wall behind their closet. Resident #12 stated they don't see them often but would feel better not seeing them at all. When asked how seeing cockroaches made them feel they stated it made them feel like I want to get up and smash them, but I can't get up. On 12/10/25 at 11:25 AM, Surveyor #1 was seated at the 2nd floor nurses' station, the surveyor observed a cockroach crawling on the wall next to the medication cart. The surveyor alerted the Licensed Practical Nurse who was nearby, who then used a cardboard piece to kill the cockroach. On 12/10/25 at 11:30 AM, during an interview with a CNA assigned to the 2nd floor, she informed Surveyor #1 that the cockroaches were all over the facility, staff had to keep their bags wrapped in plastic bag to prevent them from crawling on their belongings. The surveyor went to the 2nd floor (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	staff lounge and observed all staff bags wrapped in plastic bag on the counter.On 12/10/25 at 11:40 AM, the surveyor interviewed four random residents on the 2nd floor and inquired if they had observed cockroaches in their rooms. Resident #1 stated that they observed cockroaches crawling on the wall most of the time. When inquired regarding how they feel about the cockroaches being in the room, they stated, they were scared. Resident #2 stated, I see them all the time on the walls and when I see them on the floor next to the bed, I step on them and kill them. Resident #2 added, it is disturbing when the facility had advertised itself as a 5-star facility. Resident #3 stated that the roaches would crawl on the wall, and from the bed they saw the roaches coming from the dresser in the room. Resident #3 stated, I cannot get to them, I am bedbound. On 12/11/25 at 1:17 PM, the survey team met with the Corporate Director of Nursing, the LNHA and DON to further review the above-mentioned findings regarding the cockroaches. When asked about the chipped dresser that was still in disrepair, the LNHA stated that was not prioritized, we know furniture in general was an issue, the ones that were jagged that could cause a skin tear were replaced. The surveyor asked if the lifting broken dresser top was homelike, and the LNHA stated no.On 12/11/2025 at 3:09 PM, the survey team met with the above facility representatives and no additional information was provided. NJAC 8:36-4.1(a)11; 27.3(c); 31.5(a)(1)(2); 31.8(e)

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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. **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 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 resident during the night, and the Resident had two incontinence briefs on at that time (3:00 PM to 11:00 PM shift). She stated she assumed that the resident needed two incontinence briefs. The CNA stated that she could not recall when Resident #135 was last changed during her shift. The CNA stated, usually incontinence care was provided every two hours, but one CNA called out last night and the workload was heavy.On 12/09/25 at 11:50 AM, the surveyor interviewed the LPN/UM #2 on the second floor. The LPN/UM #2 stated that the CNAs were responsible for providing incontinence care every two hours and as needed. On 12/09/25 at 1:22 PM, an interview with the Director of Nursing (DON) revealed that the CNAs were in-serviced regarding incontinence care. The DON further stated the facility's policy was to provide incontinence care at least every 2 hours during the shift and no resident should have to wear more than one brief. b. On 12/10/25 at 11:40 AM, a lingering odor of urine permeated in the hallway across Resident #121's room. At 11:43 AM, the surveyor entered Resident #121's room and observed the resident in bed with the sheet over their head. The surveyor observed a medication cup with 4 tablets inside the cup and a cup of water on the bedside table. The surveyor greeted the resident and attempted to engage with the resident. The resident was very drowsy and could not proceed with the conversation. The surveyor went to the hallway and observed one resident standing at the door in front of the resident's room and some ancillary staff in the hallway. At 11:48 AM, the Unit Manager (UM) entered the room and observed the medication cup with 4 tablets in the cup and a cup of water next to the medication cup. The UM removed the medications at the bedside and returned to the nursing station.On 12/10/25 at 11:55 AM, the surveyor interviewed the UM regarding the medication left unattended at the bedside. The UM stated that the nurses were not allowed to leave medications unattended at the bedside for safety reasons. The UM stated the nurses were to ensure that all residents swallowed their medications before initialed the Medication Administration Record. The surveyor asked the UM to print the Medication Administration Record (MAR).On 12//10/25 at 12:05 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to the North Side where Resident #121 resided. The surveyor reviewed the Medication Administration Record with the LPN who identified the tablets in the medication cup as Lasix (a diuretic used to treat congestive heart failure) 40 milligrams (mg), Zyprexa oral tablet 5 milligrams, medication used to treat schizophrenia, Entresto (24-26 mg) a combination of Sacubitril-Valsartan) used to treat heart failure, and Pepcid 20 mg used for esophageal reflux. The nurse informed the surveyor she administered the medications and initialed the MAR at 8:41 AM (over three hours prior) and the medications were checked off as administered in the MAR. The LPN stated that possibly the resident spit the medications after they were administered. The surveyor and the UM observed the tablets in the cup. The tablets were dry, they were no residual substance which would indicate the resident spit the medications after they were administered. The surveyor then asked the LPN what the facility's protocol was for medication administration. The LPN stated, I should ensure that the resident swallowed the medications before initialed the MAR.On 12/10/25 at 1:35 PM, the surveyor returned to the 3rd floor and observed Resident #121 in bed, they were alert. The surveyor inquired regarding the medications observed on the bedside table at 11:43 AM this morning. The resident stated, It is my heart that is not right ma'am and they left the medication on the table and I did not have the strength to reach for the cup. When inquired if it was the first time that staff left medications at the bedside, Resident #121 did not answer.On 12/10/25 at (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2:15 PM, the Director of Nursing approached the surveyor and stated that the UM called and reported the incident with the medications left unattended at the bedside. The DON provided the facility's medication administration which reflected under procedure the following: No medications will ever be left in a resident room or on the medication cart unattended. On 12/11/25 at 1:17 PM, during a pre-exit meeting held with the survey team and the administrative staff (DON, Regional Director of Nursing and the Licensed Nursing Home Administrator) the surveyor reviewed the concerns regarding Resident #121's medications left at the beside unattended and required additional information. On 12/11/25 at 3:09 PM, the facility administrative staff informed the survey team that they did not have any additional information to present.c. On 12/05/2025 at 7:00 AM, Surveyor #1 toured the 4th floor and a strong odor of feces permeated the hallway on the North side. The surveyor requested a CNA assist with an observation of care in the room where the odor was identified. The CNA informed the surveyor that Resident #21 was incontinent of bowel and bladder. Resident #53, the roommate was in bed and was wearing a surgical mask. Resident #53 informed the surveyor that they could not stand the smell, and when asked if they informed staff, Resident #53 stated they informed the night nurse of the horrible smell. Resident #53 stated that Resident #21 vomited into the garbage can in the middle of the night and there was feces left in the bedside commode. The CNA confirmed that there was still vomit in the garbage can and feces permeated the room. Surveyor #1 then interviewed the 11:00 PM to 7:00 AM Licensed Practical Nurse (LPN) regarding Resident #53's concerns. The LPN confirmed that the feces and vomit were due to Resident #21 being sick overnight and she had been aware of Resident #53's concerns. The LPN stated when Resident #53 informed her of the vomit and feces smell, she assessed Resident #21 and she thought the CNA cleaned the bedside commode. The LPN stated, the CNA knew better, she went to school. The LPN continued and stated that she was the only one on the floor, it is a lot. When asked if the odor of feces and vomit was still there, she confirmed that it was and stated, she didn't have the time to go back and check if it was cleaned and confirmed that the CNA did not clean it. d. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes, indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. Direct care staff member means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021:One CNA to every eight residents for the day shift.One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: andOne direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.As per the Nursing Staffing Report completed by the facility as documented below:For the week of Complaint staffing from 02/09/2025 to 02/15/2025, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows:-02/09/25 had 15 CNAs for 171 residents on the day shift, required at least 21 CNAs.-02/10/25 had 19 CNAs for 170 residents on the day shift, required at least 21 CNAs.-02/15/25 had 20 CNAs for 170 residents on the day shift, required at least 21 CNAs.For the week of Complaint staffing from 07/20/2025 to 07/26/2025, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows:-07/20/25 had 18 CNAs for 168 residents on the day shift, required at least 21 CNAs.-07/21/25 had 19 CNAs for 168 residents on the day shift, required at least 21 CNAs.-07/23/25 had 20 CNAs for 166 residents on the day shift, required at least 21 CNAs.-07/24/25 had 19 CNAs for 166 residents on the day shift, required at least 21 CNAs.-07/25/25 had 19 CNAs for 166 residents on the day shift, required at least 21 CNAs.-07/26/25 had 14 CNAs for 166 residents on the day shift, required at least 21 CNAs.For the week of Complaint staffing from 08/03/2025 to 08/09/2025, the facility was deficient in CNA staffing for residents on 7 (continued on next page)

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Trenton Gardens Rehabilitation and Nursing Center	512 Union Street Trenton, NJ 08611

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of 7 day shifts as follows:-08/03/25 had 17 CNAs for 174 residents on the day shift, required at least 22 CNAs.-08/04/25 had 19 CNAs for 174 residents on the day shift, required at least 22 CNAs.-08/05/25 had 20 CNAs for 173 residents on the day shift, required at least 22 CNAs.-08/06/25 had 20 CNAs for 173 residents on the day shift, required at least 22 CNAs.-08/07/25 had 18 CNAs for 173 residents on the day shift, required at least 22 CNAs.-08/08/25 had 17 CNAs for 173 residents on the day shift, required at least 22 CNAs.-08/09/25 had 17 CNAs for 173 residents on the day shift, required at least 22 CNAs.For the week of Complaint staffing from 09/28/2025 to 10/04/2025, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows:-10/04/25 had 19 CNAs for 161 residents on the day shift, required at least 20 CNAs.On 12/10/25 at 11:02 AM, the surveyor interviewed the Human Resources Director (HRD) who confirmed she oversaw the facility nurse staffing. She stated to the surveyor the facility was able to meet the minimum staffing requirements which were one CNA to every eight residents for the day shift, one direct care staff member to every 10 residents for the evening shift, and one direct care staff member to every 14 residents for the night shift. The HRD stated she followed a PAR established by the owners of the facility to make the weekly schedule. On 12/11/25 at 1:18 PM the surveyor interviewed the Director of Nursing (DON) who stated the minimum staffing requirements. The DON stated the facility did there best to meet the requirements but acknowledged they are not always able to meet the requirements, that on the night shift they had the hardest struggle. The DON stated the facility offered numerous incentives to staff to encourage attendance and for working additional shifts and also had plans for future recruitment for new staff.A review of the facility Policy and Procedure on Nurse Staffing Standards and Requirements undated included . Purpose: To provide adequate nursing coverage to meet the care and acuity of the facility's residents. To make efforts to meet the regulations set forth in the NJ Administrative Code, Title 8, Chapter 43E recognizing the challenges experienced by the national nursing shortage. PAR levels will be established to meet the ratio of nurse aides to facility census as set forth in the above NJ Administrative Code. Day Shift ratio 1 aide to every 8 residents, Evening shift ratio1 aide to every 10 residents and Night shift ratio 1 aide to every 14 residentsNJAC: 8:39-27.1 (a)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to complete a performance review of Certified Nurse Aides (CNA) at least every 12 months. The deficient practice was identified for 5 of 5 Certified Nurse Aides reviewed and the deficient practice was evidenced by following: A review of the facility-provided CNA annual performance evaluations revealed that 5 of the 5 CNAs did not have an annual performance evaluation for 2024.On 12/10/25 at 1:11 PM, the surveyor interviewed the Director of Nursing who confirmed that there was no system in place to document performance evaluations for the requested CNAs. The DON and could only provide checklists for the CNAs.On 12/11/25 at 10:15 AM, the surveyor interviewed the Assistant Director of Nursing who Nursing who stated that there is not a person in the facility dedicated to check the competency of the staff providing care.On 12/11/25 at 11:55 AM, the survey team interviewed the Licensed Nursing Home Administrator, who acknowledged that the education in the building was not being done correctly and confirmed there are no staff competencies being completed.A review of the facility's Policy and Procedure In-service Nursing Aid Training, dated December 2024, the policy revealed: [.] The facility completes a performance review of nurse aides at lease every 12 months [.]Annual in-service: ensure the continuing competence of the nurse aides; are no less that 12 hours per employment year; address areas of weakness as determined by the nurse aide performance reviews; address the special needs of the residents, as determined by the facility assessment; include the training that addresses the care of residents with cognitive impairment; and include training in dementia management and resident abuse prevention .NJAC 8:39-43.17(b)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and document review it was determined that the facility failed to ensure the Facility Assessment identified competencies and skill sets that were necessary to provide the level and types of care needed for the resident population. This deficient practice affected all residents who resided on 3 of 3 resident units and was evidenced by the following: On 12/2/25, during the entrance conference, the facility provided a copy of the Facility Assessment which revealed under Services and Care Provided: Other Special Care Needs: dialysis, chemotherapy, radiation, ostomy care, tracheostomy, ventilator care .On 12/10/25 at 1:11 PM, the surveyor interviewed the Director of Nursing who confirmed that there was no system in place to document the amount of hourly training and/or performance evaluations for the requested CNAs. The DON could only provide checklists for the CNAs without any specifics related to the amount of training. On 12/11/25 at 9:31 AM, the surveyor interviewed the facility Infection Preventionist (IP). When asked if the IP ever completed staff competencies? The IP stated besides handwashing, there were no other competencies provided.On 12/11/25 at 10:15 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) regarding her role. The ADON stated she oversaw the nurses and completed audits. When asked if she physically observed nursing staff provide care, she stated, no, I don't physically observe care. The surveyor asked if she was involved with staff education? The ADON stated, I do education if there was a need. The ADON stated if there was an updated Care Plan for a resident. The surveyor asked if she completed annual competencies on the staff, or did the facility have an annual education schedule? The ADON, stated, no, I do not. When asked who was responsible for education, the ADON stated that sometimes the DON completed education. The ADON stated we used to have an online company and now the facility used another online company since the transition occurred with the new owners. The surveyor asked about dialysis residents, as they were listed on the Facility Assessment, and was it important to know how to care for a resident who required dialysis, including knowing how to check a dialysis catheter? The ADON stated, yes, but we don't have a person to do that. The surveyor asked how would you know if staff was competent, the ADON stated, they can ask me or a charge nurse. The surveyor asked was it important to know if staff could use mechanical lifts? The ADON again stated, yes, but they don't have a person for that. The surveyor asked how do you know your staff is competent, the ADON stated, they have been here a long time, but to actually know if staff have done something correctly, no, I don't have a person to do that. The surveyor asked if residents had tracheostomies (trach)? The ADON stated yes, and when asked how do you know that staff provide appropriate trach care? The ADON stated I can't tell you; they are seasoned nurses. When asked how do you know that the agency staff knows what to do, the ADON stated, I cannot tell you, I don't have an educator to demonstrate back. On 12/11/25 at 11:55 AM, the survey team interviewed the Licensed Nursing Home Administrator, who acknowledged that the education in the building is not being done correctly and that there are no competencies being completed.NJAC 8:39-43.17(b)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review it was determined that the facility failed to ensure a comprehensive, data-driven Quality Assurance Program (QAPI) was implemented and sustained during leadership transition and focused on resident outcomes and quality of life to ensure for an ongoing infestation of cockroaches that was documented as observed on the 3rd floor beginning 6/1/24, and affected 3 of 3 resident units.The deficient practice was evidenced by the following:Refer to 584F, 925F, and 880F The surveyors observed cockroaches during the following observations:- On 12/2/25 at 8:05 AM, Surveyor #1 entered Resident #135's room with two Certified Nurse Aides (CNA's) to observe incontinence care. 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. -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, and 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 12/5/25 at 11:06 AM, Surveyor #5 conducted a building tour with the Licensed Nursing Home Administrator (LNHA) and observed cockroaches swarming on the hinged side of the bathroom door in room [ROOM NUMBER] and roach feces were on the door frame.-On 12/05/2025 at 12:25 PM, Surveyor #4 interviewed the LNHA stated he had been the LNHA since 8/26/25 and he scheduled a meeting with the pest control company the first day. When asked the LNHA if he has seen cockroaches? The LNHA stated yes, it is a problem. When asked if the current pest management program was effective, he reiterated, he knows 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 12/10/25 at 11:25 AM, while seating at the nursing station, Surveyor #1 observed a cockroach crawling on the wall next to the medication cart. The surveyor alerted the staff, a Licensed Practical Nurse who was nearby used a cardboard to kill the roach. On 12/09/25 at 9:10 AM, the surveyor interviewed the supervisor for the Pest Management Company (SPM) with the LNHA present. The SPM stated he oversees the facility pest management program and when asked about the cockroaches that per the pest logs were identified in June 2024. The SPM stated the facility did not ensure the rooms were appropriately prepared for pest management services and the rooms had to be cleaned and emptied. The surveyor asked what the specifics of the new cockroach program were. The SPM stated that residents must vacate their rooms and the facility must remove all resident items. Th SPM stated the German roaches could have 30 egg sacks per roach and the gel bait dust would not work unless the resident was out of the rooms. The SPM stated people can bring the roaches into the facility, they are dirty roaches and the worst to get rid of. When asked if the German cockroaches can transmit disease, the SPM stated, yes, they can. The surveyor asked what the facility was doing to eliminate the cockroaches and ensuring residents do not bring them to the facility. The LNHA stated there was nothing in place to ensure residents coming to the facility as new admissions were not bringing in cockroaches. The surveyor asked if cockroaches crawled on linens and clothes was that, okay? The LNHA stated, that was not okay, nobody wants roaches. Asked about Resident #31's clothing and personal belongings that were in the closet with swarming cockroaches? The LNHA stated, it wasn't washed or anything. The SPM stated, the clothes should be removed, bagged, washed, because whatever is not treated, the bugs will come back. On 12/09/25 at 9:40 AM, the surveyor asked the LNHA what is being done to ensure the cockroaches are irradicated after they are on personal belongings and clothing? The LNHA stated there is no process (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in place regarding the clothing and personal belongings. This was 5 days after the survey team notified the LNHA of the observations in Resident #31's closet and the resident's desire to have belongings washed and the closet cleaned out. On 12/09/25 at 4:12 PM, the Regional Director of Nursing (RDON), Director of Nursing and LNHA addressed the survey team. The RDON stated, we know the pests are a problem and we don't think what we have done has achieved the objective, even if we have to evacuate the building, they will, we are going to take an aggressive approach. The LNHA stated the 6 to 7 rooms per what we are doing is probably not working. On 12/11/2025 at 11:55 AM, the surveyor interviewed the LNHA in the presence of the survey team. The LNHA confirmed he oversaw QAPI and if the facility identified concerns, they would add to QAPI and develop a performance improvement plan. The surveyor asked what QAPI's were in place. The LNNHA stated the facility reviewed falls, a QAPI related to splints, side rail use and consents. When asked if there was any QAPI transferred to him from the prior administration, and he confirmed there was none.The Quality Assessment and Performance Improvement Plan , undated revealed: The facility shall establish and maintain a QAPI Committee that oversees the identification and handling of the quality issues. This plan is under the guidance of the owners and administrator of Water's Edge. Goals of the Committee: To oversee facility systems and processes related to improving quality of care and services; To help identify negative outcomes relative to resident care and resolve them appropriately; To coordinate and facilitate communication regarding the delivery of quality resident care within and among departments and service, and between facility staff, residents, and family members. NJAC 8:39-33.1

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 surveyor asked what the follow-up had been with Resident #31's clothing and personal belongings after the surveyor informed him that the cockroaches were swarming in Resident #31's closet four days prior. The LNHA stated, it wasn't washed or anything. The SPM stated the clothes should be removed, bagged, and washed, because whatever is not treated, the bugs will come back. On 12/09/25 at 11:30 AM, the surveyor interviewed the Infection Control Preventionist regarding the above observation, she stated that she was made aware of the roach crawling inside the clean linen cart. When inquired if she was involved or if the facility had a plan to control the infestation, she stated, No. The IP added that the concern with the roaches was handled by the maintenance director. On 12/10/25 at 8:48 AM, Surveyor #2 interviewed an unsampled resident (UR) who resided on the third floor, The surveyor asked the resident if the resident observed cockroaches in the facility. The resident stated, I saw one yesterday, and when asked how they felt about the cockroaches, they stated it made them feel extremely angry, because if they are crawling on my face, then they are crawling on other people's faces. The resident stated they have seen cockroaches ever since they have been at the facility and stated they are a different kind of roach, much smaller. The resident further stated, I saw them coming up the wall, so I block my bed with towels to stop them from crawling on the wall onto my bed. The surveyor observed seven towels rolled up and placed on the long edge of the bed that was next to the wall. The resident stated, I do everything I can to keep them off of my face. On 12/10/25 at 10:32 AM, Surveyor #3 interviewed Resident #7 in their room while they were seated on the side of their bed. When asked if they had seen any pests like cockroaches in their room, they stated see them and had been killing them. Resident #7 stated the facility had only treated certain rooms and not the whole floor. When asked how this made them feel Resident #7 stated terrible, and then stated, once, a while back my food was delivered and I took the top off, and a roach crawled out. Resident #7 stated the housekeepers don't clean very well and stated, I keep my room clean myself and showed the surveyor their personal broom and dustpan. The resident confirmed he had spoken to maintenance about the roach problem, but it didn't do any good, the problem had been going on for over a year. Resident #7 then stated a few weeks ago they had a roach crawling on him while in bed, and then they had to knock it off and then stepped on it. On 12/10/2025 at 10:38 AM, Surveyor 3 observed Resident #12 in their room seated on the side of his bed watching television. When asked if the resident had seen any pests like roaches in their room, they stated they had noticed roaches in their room. Resident #12 stated yesterday they saw a roach crawling on the wall behind their closet. Resident #12 stated they don't see then often but would feel better not seeing them at all. When asked how seeing cockroaches made them feel they stated it made them feel like I want to get up and smash them, but I can't get up. Resident #12 stated they had never seen a cockroach in their bed and confirmed there were no roach traps in their room. On 12/10/2025 at 10:39 AM, Surveyor #4 interviewed the newly hired Maintenance Director (MD), who stated he was the former Maintenance Assistant and had worked at the facility for a few years. When asked about the cockroaches, the MD stated, it has been an ongoing problem here for years, and it is the worst I have ever seen them. The surveyor asked the MD if he ever read the Service Inspection Reports/Invoices (SIR)? The surveyor read one report dated 9/25/24 regarding treating room [ROOM NUMBER], #204, #205, #206, #207, #208 and #209 for roach activity . Under General Comments/Instructions: Recommend better sanitation, floors was really sticky and moderate food/trash in the rooms Asked if he recalled any follow-up regarding that recommendation, and stated (continued on next page)

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Trenton Gardens Rehabilitation and Nursing Center	512 Union Street Trenton, NJ 08611

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	he did remember that and maybe a word-of-mouth thing. A second SIR also dated 9/25/24 revealed Treated room [ROOM NUMBER] for roach activity, and Under General Comments/Instructions: Recommend better sanitation, observed moderate food and trash in rooms. On 12/10/25 at 11:25 AM, while seating at the nursing station, Surveyor #1 observed a cockroach crawling on the wall next to the medication cart. The surveyor alerted the staff, a Licensed Practical Nurse who was nearby used a cardboard to kill the roach.That same day at 11:30 AM, during an interview with a CNA assigned to the unit, she informed the surveyor that the roaches were all over the facility, staff had to keep their bags wrapped in plastic bag to prevent them from crawling on their belongings. The surveyor went to the 2nd floor staff lounge and observed all bags wrapped in plastic bag on the counter.On 12/10/25 at 11:40 AM, the surveyor interviewed four random residents on the 2nd floor and inquired if they had observed cockroaches in their rooms. Resident #1 stated that they observed cockroaches crawling on the wall most of the time. When inquired regarding how they felt about the cockroaches being in their room, they stated, they were scared. Resident #2 stated, I see them all the time on the walls and when I see them on the floor next to the bed, I step on them and kill them. Resident #2 added, it is disturbing when the facility had advertised itself as a 5-star facility. Resident #3 stated that the roaches would crawl on the wall, and from the bed they saw the roaches coming from the dresser in the room. Resident #3 stated, I cannot get to them, I am bedbound. On 12/11/25 at 9:31 AM, the surveyor interviewed the facility Infection Preventionist (IP), in the presence of the survey team. The surveyor asked if cockroaches were an infection control concern and the IP stated, yes, because they are bugs. When asked what her involvement related to infection control due to the cockroach infestation, the IP stated, I did rounds to make sure there was no improper food storage. When asked if there was anything in particular about the breed of cockroaches identified in the facility, the IP stated, I have not had any time to research these roaches, I am not a roach expert. When asked had she been informed of the type of cockroaches that have been in the facility, and she stated no. The surveyor asked if she had been made aware of cockroaches crawling on residents, or on residents' personal belongings, and she stated no. The surveyor asked the IP has spoken with the pest management company regarding the cockroach concerns and she stated, No, maintenance deals with it.On 12/11/25 at 11:02 AM, the surveyor conducted a telephone interview with the Medical Director (MDR) in the presence of the survey team. The surveyor asked the MDR if he was involved in infection control? The MDR stated, yes, he had been working on policies and reviewed antibiotic stewardship. The surveyor asked the MDR if he had been made aware of the facility had German cockroaches on all units. The MDR stated he was made are of the cockroaches a few weeks ago. The surveyor asked if he had been made aware that cockroaches crawled on residents and were on their personal belongings? The MDR stated that fecal matter from cockroaches, the droppings can cause ocular (eye) issues with the residents, and stated, I have to be updated. The surveyor asked the MDR if he had been updated by the IP regarding the cockroaches and he stated, the Director of Nursing told him there was a problem with cockroaches. When asked if he knew one of the residents used rolled up towels against the wall to prevent the cockroaches from crawling up the wall? The MDR stated he did not know the specifics and did not know that the cockroaches have been at the facility for over one year. The MDR stated, that is horrible, that is very serious and that is very disturbing. When asked if the MDR had been updated by the facility on the plan for the cockroaches, he stated no.' A review of the unsigned Infection control Preventionist Job Description, Updated January 2025 revealed: Job Summary: The purpose of this position is to plan, organize, develop, implement, and interpret the programs, goals, objectives, policies, procedures, etc. Of the Infection Control Committee and to coordinate the systematic monitoring of causes, spread of infection, prevention. Main Duties: c. Establish specific policies and procedures for Infection Control as it relates to the following departments: a) nursing, b) maintenance, c) laundry, d) dietary, e) rehabilitation, f) ancillary services.b. On 12/5/25 at 11:30 AM, the surveyor interviewed the Maintenance Director (MD) regarding measures in place to prevent potential for Legionella at the facility. The surveyor requested (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the water management and the facility policy for Legionella prevention. The MD informed the surveyor that the Licensed Nursing Home Administrator had the binder in their office. The surveyor requested the log for any water testing and measures that have been implemented for Legionella prevention.On 12/09/25 at 1:10PM, the surveyor met with the MD and again requested all information regarding the facility measures that were in place to prevent Legionella. The MD stated that he informed the LNHA, and the LNHA will provide the binder.On 12/11/25 at 10:30 AM, the surveyor requested again the information for Legionella testing from the facility management, no information was provided. The facility did not provide the policy or any process that was in place to prevent Legionella. The MD stated if the LNHA did not provide it, we do not have it. On 12/11/25 at 2:55 PM, the DON confirmed there was no facility water management program. The facility was unable to provide any documentation that the water had been tested for Legionella.NJAC 8:39-31.5 (a)(1)(2)

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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	Keep all essential equipment working safely. 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 (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 the ice machines, the MD stated, he never did and was unaware if the machines were cleaned. The MD stated when the new company took over the building, they did away with the service contracts for the ice machines, then stated the former company had the ice machines cleaned monthly and they looked clean. The MD stated there was a leak in the ice machine located in the 4th floor dining room, and when the company was called in for service for the leaking machine, the service company informed the facility that all the machines should be replaced due to wear and tear. The MD stated he could confirm that he changed the ice machine filters in August 2025, but that was the only maintenance that could be confirmed. A review of the facility provided manufacturer ice machine manual revealed: Section 4 Maintenance: Descaling and Sanitizing: Descale and sanitize the ice machine every six months for efficient operation. If the ice machine requires more frequent descaling and sanitizing, consult a qualified service company to test the water quality and recommend appropriate water treatment. If required, and extremely dirty ice machine may be taken apart for descaling and sanitizing. Sanitizing for exterior, remedial, and detailed procedures can be performed independently and more frequently than descaling when needed. Using non [manufacturer's name redacted] may result in bodily harm and/or cause damage to the ice machine . Exterior cleaning: Weekly: remove grill from scrap ice tray and wipe splash panel, scrap ice tray and grill with sanitizer and water solution. Pour excess solution in scrap ice tray to clear drain. The ice machine has three separate cleaning procedures: Preventative Maintenance Descaling Procedure: Perform this procedure as required for your water conditions. Recommended monthly. Allows descaling the ice machine without removing all the ice from the bin. Descaling/Sanitizing Procedure: This procedure must be performed a minim of one every six months. All ice must be removed from the bin; The ice machine and bin must be disassembled descaled and sanitized; The ice machine produces ice with the descaler and sanitizer solutions.; All ice produced during the descaling and sanitizing procedure must be discarded. Heavily Scaled Descaling Procedure: Perform this procedure if you have some or all these symptoms: . The ice machine has not been on a regular maintenance schedule. Run a descaling procedure as described above after this procedure is complete. Note: A sanitizing procedure must be performed after all descaling procedures have been completed. Sanitizing Procedure: Ice machine sanitizer is used to remove algae or slime. It is not used to remove lime scale or other mineral deposits.NJAC 8:39-31.4(a)(b)(f)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review it was determined that the facility failed to have an effective pest management program to irradicate an infestation of German cockroaches. The deficient practice occurred on 3 of 3 resident units and was evidenced by the following:Refer to 584F and 880F On 12/2/25 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 2/28/25. A further review of the Pest Management Logs (PML) for the 2nd floor revealed the following documented facility cockroach observations:- 2/28/25 Room #'s 214, 216, 213 Roaches- Bathroom/Room.- 4/16/25 Cockroach Room # 231B.- 4/21/25 Roaches spotted in room [ROOM NUMBER].- 4/22/25 Roaches in dayroom/bathroom.- 5/6/25 Ants and Roaches room [ROOM NUMBER] near air conditioner.- 5/14/25 Roaches room [ROOM NUMBER].- 6/10/25 Roaches 2nd floor medication room.- 6/13/25 Roaches 2nd floor medication room.- 7/16/25 Roaches.- 7/17/25 Roaches room [ROOM NUMBER].- 7/24/25 Please see rooms 208, 211, 215, 206, 209, 213, 226 and 230 for roaches please!!! Thank you, infested bad!! - 8/19/25 Roaches in Curtain room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER].- 8/25/25 Roaches room [ROOM NUMBER] and #207.- 8/27/25 Roaches in room [ROOM NUMBER] and #211 (Cracks in ceiling over mirror and baseboards).- 9/10/25 Complete infestation of roaches in room [ROOM NUMBER] and #215!!!, Roaches!!, Walls, floors, doors, bed!!! Sink!! Everywhere! Please Address ASAP, Infestation!!-11/13/25 Roaches 2nd Floor, #214.-10/14/25 Roaches, room [ROOM NUMBER], #208, #211, #213, and #230.-11/14/25 Roaches room [ROOM NUMBER].-11/18/25 Roaches room [ROOM NUMBER], #211(underneath sink), #214 and #227.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.A further review of the Pest Management Logs (PML) for the 3rd floor revealed the following documented facility cockroach observations:-6/1/24 Roaches in main dining room, back of nursing station.-7/2/24 Roaches in dining room.-7/16/25 Roaches in dayroom cabinets.-7/25/24 Resident found bug in bed, room [ROOM NUMBER]B.- 9/1/24 Main dining room roaches all around ice machine.-10/8/24 Roaches room [ROOM NUMBER].-11/18/24 Roaches room [ROOM NUMBER] Closet.-1/28/25 Infestation roaches under sink in bathroom.-2/19/25 Roaches Infested room [ROOM NUMBER], #307, #308, Under sinks and bathroom roaches, room [ROOM NUMBER], #327 and #330.-3/2/25 Roaches in bathroom.-3/5/25 Roaches all over in room [ROOM NUMBER].-4/23/25 Roaches 3rd floor all over the room [ROOM NUMBER].-5/30/25 Cockroaches on nurses stated.-6/13/25 Roaches room [ROOM NUMBER], #304, #305, #306, #308, #309.-7/2/25 Roaches 3rd Floor.-7/9/25 Roaches 3rd Floor.-7/28/25 Roaches room [ROOM NUMBER]B.-7/29/25 Roaches room [ROOM NUMBER]B.-8/8/25 Roaches room [ROOM NUMBER] and #328.-8/25/25 Roaches (multiple) room [ROOM NUMBER]B.-9/16/25 Roaches room [ROOM NUMBER]B.-10/12/25 Roaches, whole in wall room [ROOM NUMBER]B.-10/14/25 Roaches room [ROOM NUMBER]B.-10/21/25 Roaches (air con (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	area and hallway) room [ROOM NUMBER]B.-10/29/25 Roaches at nursing station.-11/10/25 Roaches in drawers room [ROOM NUMBER]B.-11/14/25 Roaches room [ROOM NUMBER] and #302.-11/17/25 Roaches All over room [ROOM NUMBER] floor.-11/26.25 Roaches Room #s302 and #303.-11/30/25 Roaches Room #s301, 304, 302 (inside drawers and cabinets).-12/1/25 Roaches nurses station kitchen.-12/2/25 Roaches in dining room by refrigerator.-12/3/25 Roaches in room [ROOM NUMBER]A behind television and dresser. 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 7/28/25.A further review of the Pest Management Logs (PML) for the 4th floor revealed the following documented facility cockroach observations:-7/28/25 Roaches in Room and bathroom [ROOM NUMBER].-7/30/25 Roaches in room [ROOM NUMBER].-7/30/25 Roaches in room [ROOM NUMBER].-11/5/25 Roaches in room [ROOM NUMBER].-11/14/25 Roaches in room [ROOM NUMBER].-11/18/25 Roaches in room [ROOM NUMBER].On 12/5/25 at 11:06 AM, Surveyor #5 conducted a building tour with the Licensed Nursing Home Administrator (LNHA) and observed cockroaches swarming on the hinged side of the bathroom door in room [ROOM NUMBER] and roach feces were on the door frame. During the tour of Resident #31's room, the resident stated that the cockroaches were in the room and closet and when asked if the facility had addressed the concerns, Resident #31 stated the pest control company was in their room on 11/25/25 and a monitoring station was observed under the sink counter which was located inside the room and had several dead cockroaches trapped in it. At that time, Surveyor #5 asked the LNHA if there was any ongoing pest management and he stated he began an aggressive pest management program with the existing pest company about three months ago as he was made aware of the cockroach problem after he arrived. During the tour complaints of roach sighting came from residents located in room [ROOM NUMBER]A, 327B, 417B and 419B with observations of monitoring stations with dead cockroaches trapped inside in each of the room monitoring stations. The LNHA stated the plan was to work each of the 5 floors separately, and empty 4-5 resident rooms of all the resident belongings on the day of treatment, then the pest control company would spray the room and the room would have to be kept empty to keep the resident safe from chemical exposure and the resident and belongings would then be moved back. The LNHA did not offer any plan related to the residents' belongings and personal items being exposed to cockroaches and excrement. The LNHA stated that the roaches would eat the bait and die in the chemically treated room, however, the cockroaches would be chased to the next rooms and would only die when all the rooms were treated. According to the LNHA the surviving cockroaches would continue to the next floor, and then the next until the entire building was treated. Surveyor #5 asked if the facility sanitation was being addressed as well in conjunction with the chemical management to kill the cockroaches, to ensure there was no sources to attract the cockroaches. At that time, the LNHA pointed to the hallway floors and stated they were recently cleaned and waxed, and he was working on having the same completed in the residents' rooms, however, he did not provide any specifics. On 12/05/2025 at 12:25 PM, Surveyor #4 interviewed the LNHA stated he had been the LNHA since 8/26/25 and he scheduled a meeting with the pest control company the first day. When asked the LNHA if he has seen cockroaches? The LNHA stated yes, it is a problem. When asked if the current pest management program was effective, he reiterated, he knows it is a problem. The surveyor informed the LNHA of the observations with the swarming cockroaches in Resident #31's closet and the LNHA provided the Pest Management Service Inspection Report/Invoice book.The surveyor reviewed the documents which revealed the following: -9/18/24 General Comments/Instructions: 203,204,205,206,207,208,209 Roach Treatment, unable to fully treat for service due to patients still in the room and rooms were not fully prepared. -9/25/24 General Comments/Instructions: Treated room [ROOM NUMBER] for roach activity. Treated baseboards, kitchen, bathroom, nurses' station, dining area, and common areas throughout facility . Recommend (continued on next page)

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Trenton Gardens Rehabilitation and Nursing Center	512 Union Street Trenton, NJ 08611

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	better sanitation, observed moderate food and trash in rooms.-9/25/24 General Comments/Instructions: Treated rooms 203, 204, 205, 206 207, 208 and 209 for roach activity .observed minor activity during service. Recommend better sanitation, floors were really sticky and moderate food/trash in the rooms.-12/18/24 General Comments/Instructions: Treated room [ROOM NUMBER] for roach activity .Minor activity seen during service. Recommend better sanitation throughout patient rooms.-4/9/25 General Comments/Instructions.Inspected and treated throughout kitchen and nurses' station on 4th floor. Observed live roach activity along the side of the countertop behind refrigerator, pulled out refrigerator and bated along countertop, inside fridge motor components and cabinets. Positive bait acceptance observed .-4/23/25 General Comments/Instructions: Treated rooms 203, 211, 213, 305, nurses' stations and pantry rooms on floors for control of roach activity. Observed live activity in room [ROOM NUMBER]. -4/23/25 General Comments/Instructions: ROOM [NAME] BE PREPARED 232 -roach treatment. Inspected and treated room [ROOM NUMBER] for roach activity . -5/1/25 General Comments/Instructions: Treat rooms 301 through 324 for roaches. Inspected and treated rooms 301-324 for roaches. Baited voids, nightstands, dressers and placed insect monitors throughout. Heavy roach activity observed throughout rooms; 301, 308, and 311. Roach activity was observed in all rooms on 301-316 side. Poor sanitation throughout the 3rd floor. Especially rooms 301-316. Spoke with Maintenance Director (MD) regarding observations and recommendations.-5/21/25 General Comments/Instructions: Service 5 rooms on the 3rd floor for roaches. Rooms must be prepared. Spoke with LNHA and head of maintenance. Rooms were not prepared. - 7/30/25 General Comments/Instructions: Spoke with MD and Dietary Manager. Inspected and treated throughout rooms 401, 408 and 420 for roach activity. Inspected and treated throughout rooms on 2nd floor .Inspected and treated throughout kitchen, dishwasher room, service hallway and break room. Observed roaches in kitchen oven areas and deep freezer areas.8/28/25 General Comments/Instructions: Met with new LNHA to discuss roaches and sanitation, along with the former MD. helpful with getting back on track with the roach program and the LNHA stated will have a meeting internally to discuss a few things with his staff members.On 12/09/25 at 9:10 AM, the surveyor interviewed the supervisor for the Pest Management Company (SPM) with the LNHA present. The SPM stated he oversees the facility pest management program and when asked about the cockroaches that per the pest logs were identified in June 2024. The SPM stated the facility did not ensure the rooms were appropriately prepared for pest management services and the rooms had to be cleaned and emptied. Reviewed a 5/1/25 Service Inspection Report regarding roach activity in all rooms on 301-316 side, and poor sanitation throughout the 3rd floor, and was reported to the MD, and asked if the SPM recommendations were followed, the LNHA stated he spoke with the staff regarding no food being left over from the residents and the food and meal trays were supposed to be cleaned up right away and he could not speak to May 2025. The surveyor asked the LNHA about the resident food that was observed left out on the units during survey, including on 12/2/25? The LNHA stated nothing should be left out; no meal trays should be left out. The surveyor asked what the specifics of the new cockroach program were. The SPM stated that residents must vacate their rooms and the facility must remove all resident items. Th SPM stated the German roaches could have 30 egg sacks per roach and the gel bait dust would not work unless the resident was out of the rooms. The SPM stated people can bring the roaches into the facility, they are dirty roaches and the worst to get rid of. When asked if the German cockroaches can transmit disease, the SPM stated, yes, they can. The surveyor asked what the facility was doing to eliminate the cockroaches and ensuring residents do not bring them to the facility. The LNHA stated there was nothing in place to ensure residents coming to the facility as new admissions were not bringing in cockroaches. The SPM stated 5-6 rooms need to be completed at each time. The surveyor requested the cockroach plan and any documentation related to the room treatment plan. The LNHA stated we give the company a list of 6-7 rooms to treat. The surveyor asked if cockroaches crawled on linens and clothes was that, okay? The LNHA stated, that was not okay, nobody wants roaches. Asked about Resident #31's clothing and (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	personal belongings that were in the closet with swarming cockroaches? The LNHA stated, it wasn't washed or anything. The SPM stated, the clothes should be removed, bagged, washed, because whatever is not treated, the bugs will come back. The surveyor asked the LNHA did Resident #31 have their room emptied? The LNHA stated he didn't think the room was fumigated. On 12/09/25 at 9:40 AM, the surveyor asked the LNHA what is being done to ensure the cockroaches are irradicated after they are on personal belongings and clothing? The LNHA stated there is no process in place regarding the clothing and personal belongings. This was 5 days after the survey team notified the LNHA of the observations in Resident #31's closet and the resident's desire to have belongings washed and the closet cleaned out. On 12/09/2025 at 4:00 PM, advised the LNHA of concerns regarding the environment and need to extend the survey, in the presence of Surveyor #5.On 12/09/25 at 4:12 PM, the Regional Director of Nursing (RDON), Director of Nursing and LNHA addressed the survey team. The RDON stated, we know the pests are a problem and we don't think what we have done has achieved the objective, even if we have to evacuate the building, they will, we are going to take an aggressive approach. The LNHA stated the 6 to 7 rooms per what we are doing is probably not working. On 12/10/25 at 10:39 AM, the surveyor interviewed the Maintenance Director (MD), who stated he worked at the facility for a few years and was recently promoted to Director from Maintenance Assistant. The surveyor asked about his role related to the pest management and logs. The MD stated his role was to make sure that the pest logs matched the Invoices and they were not duplicated and then he would send the Invoices to accounts payable. The surveyor asked what else he did with the Invoice Reports? The MD stated, I just file them. The surveyor asked if he had ever read them regarding the recommendations, and he stated, I read quite a few of them. The surveyor reviewed a report dated 9/25/25 regarding needing better sanitation and asked what was done? The MD stated it was discussed with housekeeping and nursing per the former MD and that was documented in the morning meeting. When asked if there was documentation related to that he stated, no. When asked about a recommendation from a 10/9/24 Invoice to Recommend maintenance sealing up voids near vent area in room [ROOM NUMBER] and 323, did he recall that being completed? The MD stated, that was vague and didn't remember anything about that since he was not the MD at that time. When asked about the recommendations regarding sanitation, he stated maybe a word-of-mouth thing. When asked about rooms not being prepped for service he stated, it happened quite often, and that had to do with nursing. When asked if the cockroaches were a problem he stated, it has been an ongoing problem here for years, is it the worst now, the facility is not really assessing the problem when they see it. The MD confirmed there were no additional Invoice reports at that time. When asked about the 5/1/25 report regarding the poor sanitation, he recalled having a discussion with the former MD about coordinating the whole right side of the wing because the 5-room thing wasn't working, but it would have been a big effort and the resident would have to be removed for 48 hours to vent and fumigate. When asked what happened, he stated, he did not hear any follow up at all, it was passed on and went nowhere. When asked if he met with the pest company when the current LNHA came, he stated it was an internal meeting and nothing was funneled down to him as he was not involved.On 12/10/25 at 2:55 PM, the LNHA provided the surveyor with a copy of the undated pest management company plan for Roach Treatment which revealed: Description of service: Our roach control service will be performed in a systematic, room -by-room order, addressing five resident rooms per service visit to ensure thoroughness, safety, and minimal disruption. Resident Preparation Requirements: 1. Prior to service, the following must be completed for each room: 1. Remove all resident belongings from drawers, cabinets, and closets. a. clothing, personal items, papers, and other contents must be taken out and placed in sealed bags or bins provided by the facility. 2. Clear all items from floors. 2. No boxes, shoes, bags, or loose items may remain on the floor. 3. Thoroughly clean the room before treatment, including: a. Sweeping and mopping floors, b. Cleaning baseboards, c. Wiping down all furniture (inside and out) such as dressers, nightstands, and bedframes, d. Removing any food debris or spills, e. Ensuring trash is removed. 4. Move furniture slightly away from the walls where possible (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to allow proper access for treatment .Post-Service Requirements: After treatment: Residents must remain out of their rooms for 3-4 hours to allow products to dry and settle safely; Rooms must remain clean and clutter-free to maximize the effectiveness of treatment and prevent re-infestation. Facility Responsibilities: Ensure staff is available to prepare rooms ahead of the scheduled service; Coordinate temporary relocation of residents for the required out-of- room period; Maintain sanitation and housekeeping standards between services. On 12/10/25 at 11:25 AM, while seating at the nursing station on the 2nd floor, Surveyor #1observed a roach crawling on the wall next to the medication cart. The surveyor alerted the staff, a Licensed Practical Nurse who was nearby used a cardboard to kill the roach. On 12/11/25 at 10:15 AM, Surveyor #4 interviewed the Assistant Director of Nursing (ADN) and asked if she was aware of the cockroaches, and she stated, I know we have roach issues. When asked if she had been involved with the pest management company to appropriately prepare the resident rooms for service, she stated that we are informed what rooms need service would then inform the Charge Nurse. When asked who followed up to ensure the resident rooms were ready for treatments, she stated, no one. When asked if there were any other steps or areas that needed to be monitored to eradicate the cockroaches besides moving residents out of rooms, and asked specifically to ensure that facility sanitation was maintained, including making sure there were no resident food trays left out. The ADON stated, no, On 12/11/25 at 1:17 PM, the survey team met with the Corporate Director of Nursing, the LNHA and DON to further review the above-mentioned findings. On 12/11/2025 at 3:09 PM, the survey team met with the above facility representatives and no additional information was provided. NJAC 8:36-4.1(a)11; 27.3(c); 31.5(a)(1)(2); 31.8(e)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on observation, interview and document review, it was determined that the facility failed to ensure a system was in ensure annual competency evaluations were completed for Certified Nurse Aides (CNAs) and they were educated based on the outcome, and a system was in place to ensure CNAs were provided with at least 12 hours of education per their annual date of employment. The deficient practice was evidenced by the following: On 12/10/25 at 11:03 AM, the surveyor reviewed the provided in-service education for 5 randomly selected CNAs for the 2024 to 2025 year, which revealed that the in-service education was a sign-off list and did not obtain an hourly audit of education training. On 12/10/25 at 1:11 PM, the surveyor interviewed the Director of Nursing who confirmed that there was no system in place to document the amount of hourly training and/or performance evaluations for the requested CNAs. The DON could only provide checklists for the CNAs without any specifics related to the amount of training. On 12/11/25 at 10:15 AM, the surveyor interviewed the Assistant Director of Nursing who stated that she has seen the facility assessment book but has not gone through it. When asked if she was aware that there was education requirements in the facility assessment, the ADON responded, yes. The ADON further confirmed that there is not a person in the facility dedicated to check the competency of the staff providing care.On 12/11/25 at 11:55 AM, the survey team interviewed the Licensed Nursing Home Administrator, who acknowledged that the education in the building done was not being correctly and that there are no competencies being completed. A review of the facility's Policy and Procedure In-service Nursing Aid Training, dated December 2024, the policy revealed: [ ] methods used used to provide training may include in-person instruction, webinars, supervised practical training, computer based training, self-directed training, mentoring, and/or coaching. [.] Supervised practical setting training means training in a setting in which instruction and oversight are provided by a person who has relevant instruction education and/pr experience specific to the subject of the training being provided. NJAC 8:39-33.4

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview, and review of facility documentation, it was determined that the facility failed to ensure that a Certified Nurse Aide (CNA) received at least 12 hours of mandatory in-service training for 5 of 5 CNAs education reviewed. This deficient practice was evidenced by the following: On 12/10/25 at 11:03 AM, the surveyor reviewed the provided in-service education for 5 randomly selected CNAs for the 2024 to 2025 year, which revealed that the in-service education was a sign-off list and did not obtain an hourly audit of education training. On 12/10/25 at 1:11 PM, the surveyor interviewed the Director of Nursing who confirmed that there was no system in place to document the hourly training and/or performance evaluations for the requested CNAs. The DON and could only provide checklists for the CNAs.On 12/10/2025 at 1:15 PM, the surveyor interviewed the Human Resources Director (HRD) who confirmed there were no competencies for the staff, and for the CNA education, there was a trifold bulletin board used with no documentation regarding any hourly training provided to CNAs. The HRD confirmed that there was no proof of the hours trained and only had a checklist. On 12/11/25 at 10:15 AM, the surveyor interviewed the Assistant Director of Nursing who Nursing who confirmed that there was no system in place to document the hourly training and could only provide checklists for the CNAs.On 12/11/25 at 11:55 AM, the survey team interviewed the Licensed Nursing Home Administrator, who acknowledged that the education in the building was not being done correctly.A review of the facility's Policy and Procedure In-service Nursing Aid Training, dated December 2024, the policy revealed: [.] The facility completes a performance review of nurse aides at lease every 12 months [.]Annual in-service: ensure the continuing competence of the nurse aides; are no less that 12 hours per employment year; address areas of weakness as determined by the nurse aide performance reviews; address the special needs of the residents, as determined by the facility assessment; include the training that addresses the care of residents with cognitive impairment; and include training in dementia management and resident abuse prevention [.]N.J.A.C. 8:39-43.17(b)

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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. **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, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 Manager (LPN/UM). The LPNUM stated that incontinence care was to be offered every two hours and as needed. The LPNUM reviewed the schedule and stated one CNA called out and there were only two CNAs for the floor. Each CNA had to care for 23 residents. The Census was 47.3. On 12/2/25 at 8:06 AM, the surveyor continued the tour and entered Resident #135's room. The surveyor observed Resident #135 in bed, their extremities appeared contracted. Resident # 135 was positioned on the right side; their eyes were opened but Resident #135 was nonverbal. The surveyor asked a random CNA to assist with an incontinence care tour observation, 2 CNAs entered the room and proceeded to perform the incontinence check with the surveyor. The surveyor observed that Resident #135 was saturated with urine. Resident #135 had a 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 had been wearing two incontinence briefs.On12/05/25 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 exit the unit. 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.Review 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.Review of the resident's Comprehensive Care Plan dated 10/06/25, revealed a focus area that the resident has preferences and interventions to help maintain his quality of life and assist with daily choices. The goal of the resident's CP was the resident's preferences will be honored and updated as they changed. The interventions for the resident's ADL Care Plan included, incontinence care, assistance with bathing and hygiene and bed mobility.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 stated she cared for the resident during the night, and the Resident had two incontinence briefs on at that time. She assumed that the resident needed two incontinence briefs. The CNA stated that she could not recall when Resident #135 was last changed during her shift. The CNA stated usually incontinence care was provided every 2 hours, but one CNA called out last night and the workload was heavyOn 12/09/25 at 11:50 AM, the surveyor interviewed the LPNUM on the second floor. The Unit Manager stated that the CNAs were responsible for providing incontinence care every 2 hours and as needed. On 12/09/25 at 1:22 PM, an interview with the Director of Nursing (DON) revealed that the CNAs were in-serviced regarding incontinence care. The DON further stated the facility's policy was to provide (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinence care at least every 2 hours during the shift and no resident should have to wear more than one brief.The facility policy titled, Resident ADL Care dated 11/11/25 indicated the following:Purpose: To ensure all residents receive person-centered, safe, and consistent assistance with Activities of Daily Living (ADLs) that promote dignity, independence, comfort, and overall quality of life.Policy: The facility is committed to providing individualized ADL care based on each resident's unique needs, abilities, preferences, and care plans. Assistance shall be provided in a manner that upholds residents' rights, dignity, privacy, and safety.NJAC: 8:39-27.1 (a)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, it was determined that the facility failed to provide the required Skilled Nursing Facility (SNF) Notice of Medicare Non-Coverage (NOMNC) for 1 of 2 residents (Resident #114) reviewed for change in insurance coverage status and remained in the facility. This deficient practice was evidenced by the following:On 12/09/25 at 9:09 AM, the Social Worker returned 2 of 3 requested beneficiary forms to the surveyor and stated, I don't have Resident #114, they didn't have a beneficiary form completed, as the resident had a guardian. The Social Worker stated that she should have informed the guardian regarding Medicare coverage ending but she did not, and stated, it fell through the cracks. On 12/09/25 at 9:11 AM, the surveyor reviewed the SNF Beneficiary Protection Notification Review (BPNR) forms for Resident #114, provided by the facility. The facility had a change in insurance coverage status and remained in the facility. The resident's last covered day for Medicare Part A Services was 9/15/25. Resident #114's SNF NOMNC form did not have a signature from Resident #114, or the resident's representative. There was no additional documentation provided by the facility regarding communication of this form to the resident or resident's representative. NJAC 8:39-4.1(a)(8)

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Trenton Gardens Rehabilitation and Nursing Center	512 Union Street Trenton, NJ 08611

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Complaint Intake NJ #2594199Based on interview, record review and review of pertinent documentation, it was determined that the facility failed to ensure an allegation of misappropriation of property was investigated. The deficient practice was identified for 1 of 1 sampled resident (Resident #154) reviewed for misappropriation property and was evidenced by the following:On 12/09/25 at 12:00 PM the surveyor reviewed Resident #154's medical record which revealed the following:The diagnoses included but not limited to; Schizoaffective disorder, Bipolar type (mental health disorder), Epilepsy (seizure disorder) and Hemiplegia (loss of voluntary movement on one side). A review of the Significant Change Minimum Data Set, an assessment tool, dated 9/29/25, indicated the resident had a Brief Interview for Mental Status score of 13 out of 15, which indicated the resident was cognitively intact. On 12/10/25 at 1:21 PM, the surveyor interviewed the Director of Nursing (DON) regarding what accommodations were in place to ensure Resident #154's safekeeping of valuables. The DON stated that if a resident wished, they could request a key and lock up their valuables inside a cabinet or dresser inside their room. The DON stated she recalled the resident and that she had not received any grievances regarding missing items for Resident #154. The DON stated items other than missing clothing must have a grievance form filed. The DON further stated that grievances were the responsibility of the Social Worker. On 12/10/25 at 1:57 PM the surveyor interviewed Social Worker (SW #2) regarding any allegations of missing items that were made by Resident #154. She stated after Resident #154 was discharged from the facility, she had a folder of Resident #154's grievance forms for the Audit nurse to review and the surveyor asked SW #2 to provide the forms for review. SW #2 then stated she misplaced the folder, I cannot locate the file. SW #2 stated she could not provide any evidence that the missing item allegations were thoroughly investigated. She recalled Resident #154's family reported missing items including a cellular phone, money and food items. Social worker #2 stated that Resident #154's family replaced the lost cellular phone. SW #2 confirmed there was no investigation completed regarding the missing cellular phone. SW #2 stated Resident #154's family had food items such as cookies, cases of root beer, ginger ale and cereal delivered to the facility. SW #2 stated Resident #154 used to give soda and cookies to other residents who assisted Resident #154 downstairs to smoke. SW #2 then stated this information was not documented and she recalled the resident also reported money went missing. SW #2 stated the resident would put money down in their clothing, and staff would find it on the floor and then returned the money to the resident. SW #2 stated that Resident #154 gave money to other residents to buy other items for the resident. SW #2 stated she had not interviewed any staff that cared for Resident #154 and had not documented any information regarding any investigations. She stated that after the surveyor brought it to her attention, and after thinking about it, I should have investigated and documented it. On 12/11/25 at 12:52 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding what should occur if a resident reported any missing item. The LNHA stated allegations are reviewed in morning meeting. On 12/11/25 at 1:21 PM, in the presence of the survey team, the LNHA and the DON denied any knowledge about any missing items or grievances for Resident #154. A review of the facility Abuse, Resident Behavior and Facility Practice Policy, dated 6/2025 revealed:Policy: The facility has procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, exploitation and misappropriation of property.Investigation: 3. The DON/Designee b.) obtains written statements of staff assigned to the Resident for: the shift during which the allegation is noted. c.) Interview witnesses, if any. d.) Reviews the Resident's record. e.) Reviews staff assignments and staff performance . h.) Reports findings to the Administrator. NJAC: 8:39 - 4.1(a)15

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to ensure an accurate ordering and receiving of narcotic medications on the required Federal narcotic acquisition forms (DEA Form 222) were completed with sufficient detail to enable accurate reconciliation of controlled-dangerous substances (narcotic medications, that due to their high potential for abuse, are tracked with a degree of detail and attention)medications ordered and received for 1 of 6 forms provided, and the facility failed to ensure medications were administered to a resident according to standards of practice (Resident #121). The evidence was as follows: a. On 12/11/2025 at 10:57 AM the surveyor reviewed the facility provided DEA 222 forms which revealed on one of the six provided forms Part 5, had not been completed upon receipt of the medications from the provider pharmacy as instructed on the reverse of the ordering form. The forms were as follows: Order form # 230236684 dated 7/22/2024, # 241009263 dated 8/29/2024, # 241009230 dated 3/4/2025, # 241009259 dated 5/28/2025, # 241009258 dated 7/30/2025, # 241009269 dated 8/7/2025, - Part 5 was not completed with the number of items received and the date they were received. On 12/11/2025 at 11:35 AM, The surveyor interviewed the Director of Nursing (DON) who stated when she received the narcotic medications from the pharmacy, she and another nurse review the packing slip to ensure what was ordered was delivered. Then she stated she completed Part 5 of the DEA 222 form. Together the surveyor and the DON reviewed the DEA 222 form #241009269 and the DON confirmed she had not completed the form as required on the reverse of the DEA 222 form. On 12/11/25 at 12:31 PM, surveyor #2 interviewed the Consultant Pharmacist (CP) who stated The DEA 222 form was a federal form and it must be completed per the board of pharmacy. The responsibility of the facility was to ensure what was requested was filled to completion and was received and not lost during transport. A review of the Instructions for DEA Form 222, under Part 5. Controlled Substance Receipt, 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item . A review of the facility's provided Controlled Substances policy with a date of 10/25/2025 and the Medication Storage policy dated reviewed 3/2025, did not include information related to the completion of the DEA 222 forms. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 12/10/25 at 11:40 AM, a lingering odor of urine permeated in the hallway across Resident #121's room. At 11:43 AM, the surveyor entered Resident #121's room and observed the resident in bed with the sheet over their head. The surveyor observed a medication cup with 4 tablets inside the cup and a cup of water on the bedside table. The surveyor greeted the resident and attempted to engage with the resident. The resident was very drowsy and could not proceed with the conversation. The surveyor went to the hallway and observed one resident standing at the door in front of the resident's room and some ancillary staff in the hallway. The surveyor asked a certified nurse aide to ask the Unit Manager (UM) to come to the room. At 11:48 AM, the Unit Manager (UM) entered the room and observed the medication cup with 4 tablets in the cup and a cup of water next to the medication cup. The UM removed the medications at the bedside and returned to the nursing station. On 12/10/25 at 11:50 AM, the surveyor reviewed Resident #121's medical record which indicated the resident was admitted to the facility on [DATE] and had diagnoses which included but were not limited to, chronic obstructive pulmonary disease, heart failure, undifferentiated schizophrenia, and other specified anxiety disorder. The Quarterly Minimum Data Set (MDS), an assessment tool, of 10/01/25, indicated that the resident's BIMS (Brief Interview for Mental Status) was 3, which indicated that the resident had severe cognitive impairment. Resident #121 had also a care plan for being resistive to care, frequent episodes of refusing medications and blood work. The intervention was to explain to the resident the importance of taking medications. On 12/10/25 at 11:55 AM, the surveyor interviewed the UM regarding the medication left unattended at the bedside. The UM stated that the nurses were not allowed to leave medications unattended at the bedside for safety reasons. The UM stated the nurses were to ensure that all residents swallowed their medications before initialed the Medication Administration Record. The surveyor asked the UM to print the Medication Administration Record (MAR). On 12//10/25 at 12:05 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to the North Side where Resident #121 resided. The surveyor reviewed the Medication Administration Record with the LPN who identified the tablets in the medication cup as Lasix (a diuretic used to treat congestive heart failure) 40 milligrams (mg), Zyprexa oral tablet 5 milligrams, medication used to treat schizophrenia, Entresto (24-26 mg) a combination of Sacubitril-Valsartan) used to treat heart failure, and Pepcid 20 mg used for esophageal reflux. The nurse informed the surveyor she administered the medications and initialed the MAR at 8:41 AM and the medications were checked off as administered in the MAR (This was three hours after the medications were observed on the side of Resident #121's bed.) The LPN stated that possibly the resident spit the medications after they were administered. The surveyor and the UM observed the tablets in the cup. The tablets were dry, they were no residual substance which would indicate the resident spit the medications after they were administered. The surveyor then asked the LPN what the facility's protocol was for medication administration. The LPN stated, I should ensure that the resident swallowed the medications before I initialed the MAR. On 12/10/25 at 1:35 PM, the surveyor returned to the 3rd floor and observed Resident #121 in bed, they were alert. The surveyor inquired regarding the medications observed on the bedside table at 11:43 AM this morning. The resident stated, It is my heart that is not right ma'am, and stated the nurse left the medication on the table and I did not have the strength to reach for the cup. When (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inquired if it was the first time that staff left medications at the bedside, Resident #121 did not answer. On 12/10/25 at 2:00 PM, the surveyor interviewed the LPN on the south side regarding the protocol for medication administration, the LPN stated that medication should be administered and signed for after residents took their medication. Nurses were not allowed to leave medication unattended at the bedside. On 12/10/25 at 2:15 PM, the Director of Nursing approached the surveyor and stated that the UM called and reported the incident with the medications left unattended at the bedside. The DON provided the facility's medication administration which reflected under procedure the following: No medications will ever be left in a resident room or on the medication cart unattended. On 12/11/25 at 2:35 PM, during a pre-exit meeting held with the survey team and the administrative staff (DON, Regional Director of Nursing and the Licensed Nursing Home Administrator) the surveyor reviewed the concerns regarding Resident #121's medications left at the beside unattended and requested any additional information. On 12/11/25 at 1:30 PM, the facility administrative staff informed the survey team that they did not have any additional information to present. A review of the facility's policy titled, Medication Administration Policy and Protocol provided by the DON last revised, reflected the following: The medication nurse will immediately document the administration of each resident's medication after administration before going onto the next resident. No medications will ever be left in a resident room or on the medication cart unattended. NJAC: 8:39-29.7(c);29.2(d)

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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. **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 (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Stress Syndrome, Substance abuse, other psychiatric diagnoses, intellectual or developmental disabilities, consult with Psychiatrist and psychologist to manage and treat.The surveyor asked for the CNA's file for review, the facility provided a checklist only. The surveyor could not determine if the CNA received training on behavioral health nor if she completed the yearly 12 hours mandatory training. Following the incident, the CNA received a corrective action notice for violations of Company Policies or procedures. The facility's assessment indicated the following under section J: training/ education and competencies skills checks are generally provided upon hire, during monthly in-servicing/ training, annual in-servicing/ training and /or wherever an area of concern is identified, or new areas are identified based on resident diagnoses and/ or clinical condition. Required in-service training for nurse aides must be done to ensure continuing competence but no less than 12 hours per year and to include dementia management, resident abuse prevention training and care of cognitively impaired. There was no documented evidence that the CNA received in-service training on Mental health and behavior.NJAC:8-39-13.4 (b)