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 _____	C 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRENTON GARDENS REHABILITATION AND NURSING CENTER	**512 UNION STREET TRENTON, NJ 08611**

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F 000	INITIAL COMMENTS COMPLAINT #: NJ175920, NJ176848, NJ179424, NJ181381, NJ182907, NJ183647, NJ184225, NJ184250, NJ184351, NJ185458, NJ186028 CENSUS: 162 SAMPLE SIZE: 18 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. F600J Based on interviews, medical record reviews, and review of other pertinent facility documentation on 5/7/25, 5/8/25 and 5/9/25, it was determined that the facility failed to ensure residents were protected from NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 when Resident #15 was observed to have NJ Exec Order 26.4b1 [redacted] The facility also failed to follow its policy titled, "Abuse, Resident Behavior and Facility Practice." On 10/12/24 at approximately 8:30 P.M, the U.S. FOIA [redacted] was notified by the Licensed Practical Nurse (LPN) #6 that Resident #15 had a NJ Exec Order 26.4b1 LPN #6 reported that Resident #8 left the room that he/she shared with Resident #1 NJ Exec Order 26.4b1 [redacted] (Resident #15). The U.S. FOIA failed to NJ Ex Order 26.4(b)(1) Resident #15 from Resident #8	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/09/2025

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.

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F 000	Continued From page 1 who was NJ Exec Order 26.4b1 The facility failed to follow its policy titled, "Abuse, Resident Behavior and Facility Practice," and protect facility residents when the U.S. FOIA failed to immediately implement the NJ Ex Order 26 policy for the NJ Ex Order 26.4(b)(1) and to ensure both residents were immediately NJ Ex Order 26.4(b)(1) This placed Resident #15 and all residents in an Immediate Jeopardy (IJ) situation. The IJ began on 10/12/24, was identified on 5/9/25 at 5:04 P.M., and was reported to the U.S. FOIA (b)(6) The U.S. FOIA (b) was presented with the F600 IJ template at that time. An acceptable removal plan was electronically emailed to the surveyor on 5/13/25 at 4:24 P.M., indicating the facility's actions to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice. All facility staff were educated on the facility's policy abuse prevention, recognition of and types of abuse, reporting urgency and reporting to the regulatory agencies. The U.S. FOIA (b)(6) audited all incidents and accidents from NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1), to assure there were no additional unresolved NJ Ex Order 26.4(b)(1) of NJ Ex Order 26 identified. On NJ Ex Order 26.4(b)(1), the U.S. FOIA (b)(6) implemented an auditing process to assess potential NJ Ex Order 26 and ensure concerns are addressed through the policy. Auditing of all accidents will occur Monday through Friday, with weekend (Saturday and Sunday) incidents included in the Monday audit. The surveyor verified the removal plan on site on 5/15/25 at 3:10 P.M and determined the IJ for F600 was removed as of 5/15/25.	F 000		

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F 000	Continued From page 2 After the IJ removal, the non-compliance continued from 5/15/25 for no actual harm with the potential for more than minimal harm that is not an immediate jeopardy. F610 K Complaint #: NJ182907, NJ186028 Based on interviews, medical records reviews, and review of other pertinent facility documentation on NJ Exec Order 26.4b1 it was determined that the facility failed to complete thorough investigations when A) Resident #15 was observed to have NJ Exec Order 26.4b1 . B) when a resident reported witnessing an NJ Exec Order 26.4b1 (Resident #3) and the Licensed Practical Nurse (LPN #1). The facility also failed to ensure its policy titled "Abuse, Resident Behavior and Facility Practice" was implemented for the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 allegations. A) On 10/12/24 at approximately 8:30 P.M, the U.S. FOIA (b)(6) was notified by LPN #2 that Resident #15 had NJ Ex Order 26.4(b)(1) . LPN #2 reported that Resident #8 left the room that he/she shared with Resident #15 NJ Exec Order 26.4b1 the resident (Resident #15). The U.S. FOIA (b) failed to conduct a thorough investigation. The U.S. FOIA (b) stated that Resident #15 was NJ Exec Order 26.4b1 (Resident #8). The U.S. FOIA (b) also said, "I spoke with both of them (Resident #8 and Resident #15) but NJ Exec Order 26.4b1 that Resident #15 NJ Exec Order 26.4 No follow up investigation was conducted outside of the grievance filed for Resident #15."	F 000		

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The facility failed to follow its policy titled, "Abuse, Resident Behavior and Facility Practice" and protect facility residents when the [U.S. FOIA (b)] failed to immediately implement the [NJ Ex Order 26] policy for the NJ Ex Order 26.4(b)(1) and to conduct a thorough investigation for the NJ Ex Order 26.4(b)(1). This placed Resident #15 and all residents in an Immediate Jeopardy (IJ) situation. The IJ began on 10/12/24, was identified on 5/9/25 at 5:04 P.M. At this time, the IJ Template was presented to the [U.S. FOIA (b)]

An acceptable removal plan was electronically emailed to the surveyor on 5/13/25 at 4:24 P.M., indicating the facility's actions to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice. All facility staff were educated on the facility's policy [NJ Ex Order 26] prevention, recognition of and types of [NJ Ex Order 26.4] reporting urgency and reporting to the regulatory agencies. The U.S. FOIA (b)(6) audited all incidents and accidents from [NJ Ex Ord] to [NJ Ex Ord], to assure there were no additional unresolved [NJ Ex Order 26.4(b)(1)] of [NJ Ex Order 26] identified. On 5/12/2025, the [U.S. FOIA (b)(6)] implemented an auditing process to assess potential [NJ Ex Order 26] and ensure concerns are addressed through the policy. Auditing of all incidents/accidents will occur Monday through Friday, with weekend (Saturday and Sunday) incidents/accidents included in the Monday audit.

B) On [NJ Ex Order 26.4(b)], Resident #2 told LPN #1 that he/she was going to report her for [NJ Exec Order 2] Resident #3. LPN #1 reported this immediately to the U.S. FOIA (b)(6) and LPN #1 was suspended. The [U.S. FOIA (b)] stated that Resident #2

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informed her on [redacted] that the [redacted] with LPN #1 and Resident #3 had occurred three weeks prior and then later stated the incident occurred six weeks ago. The [redacted] stated she conducted an investigation and suspended LPN #1 immediately after the [redacted] was reported to her. The [redacted] stated she did not conduct interviews or assessments for residents on LPN #1's assignment and did not obtain witness statements from other staff that worked on the unit when the [redacted] was made.

The facility failed to follow its policies and procedures and protect the facility residents by not conducting a thorough investigation into whether other residents or staff members had any reports of [redacted] involving LPN #1. This placed the residents being cared for by this staff member in an immediate jeopardy (IJ) situation. The IJ began on [redacted] was identified on 5/8/25 at 6:00 P.M., and was reported to the [redacted] The [redacted] was presented with the IJ template at that time.

An acceptable removal plan was electronically mailed to the surveyor on 5/13/25 at 4:23PM, indicating the facility's actions to prevent [redacted] from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice. On 5/8/25, the residents that were on LPN #1's schedule were interviewed and assessed for any complaints of [redacted] requested or witnessed by LPN #1. On 5/9/25, the [redacted] and the [redacted] educated the social workers (SW) and administrative nursing staff on the facility's policy on reporting of [redacted] and conducting a thorough

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investigation. The U.S. FOIA (b)(6) conducted an investigation into incidents and accidents from NJ Ex Order 26.4(b)(1). An audit was implemented daily at morning clinical meeting on all accidents and incidents to determine if conducted investigations were completed correctly.

The surveyor verified the removal plan on site on 5/15/25 and determined the IJ for F610 was removed as of 5/15/25.

After the IJ removal plan, the non-compliance continued from 5/15/25 for no actual harm with the potential for more than minimal harm that is not an immediate jeopardy.

F657 J

Based on interviews, medical record reviews, and review of other pertinent facility documentation on 5/8/25, it was determined that the facility failed to a.) update the care plan (CP) with interventions for a resident (Resident #6) who had [redacted] incidents while at the facility and b.) follow the facility's policy titled "Policy on Resident Care Planning."

On 2/21/25 at approximately 6:30 PM, the U.S. FOIA (b)(6) observed Resident #6 NJ Exec Order 26.4b1 in his/her wheelchair. Resident #6's NJ Exec Order 26.4b1 and he/she had NJ Exec O [redacted]. The U.S. F stated she administered NJ Exec Order 26 to the resident. NJ Exec Order 26.4b1, the resident NJ Exec Order 26.4b1 and was sent to the hospital. On NJ Exec Order 26.4, Resident #6 returned to the facility from the hospital with a diagnosis of NJ Exec Order 26.4b1. On NJ Exec Order 2, the resident was found sitting in his/her wheelchair NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 were

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NJ Exec Order 26.4b1 The doctor was notified, and the resident was sent to the hospital via 911. Resident #6 returned to the facility from the hospital with a diagnosis of NJ Exec Order 26.4b1. On NJ Exec Order 2, the resident was NJ Exec Order 26.4b1 in his/her wheelchair outside his/her room during rounds. The resident was noted to have NJ Exec Order 26.4b1 in his/her NJ Exec Order 26.4b1. The doctor was notified, and the resident was sent to the hospital. The U.S. FOIA (b)(6) stated that the NJ Exec Order 26.4b1 gave Resident #6 NJ Exec Order 26. According to the hospital Emergency Room (ER) documentation dated NJ Exec Order 2, the resident's diagnosis for the visit was NJ Exec Order .

The facility did not update Resident #6's CPs to manage the resident's NJ Exec Order 26.4b1 after the resident NJ Exec Order 26.4b1 The facility's failure to update the CP with interventions for Resident #6 to prevent further NJ Exec Order 26.4b1 placed all residents in an Immediate Jeopardy (IJ) situation. The IJ began on NJ Ex Order 26.4(, was identified on 5/8/25 at 6:00 PM., and was reported to the U.S. FOIA (b)(6) . The U.S. FOIA (b)(6) was presented with the IJ template at that time.

An acceptable removal plan was electronically mailed to the surveyor on 5/13/25 at 4:23 PM, indicating the facility's actions to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice. On 5/8/25, Resident #6's care plan was updated. On 5/9/25, the U.S. FOIA (b)(6) educated the U.S. FOIA (b)(6) on updating and

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implementing care plans when incidents occur. The [redacted] implemented a process to occur during daily morning clinical meetings to ensure that care plans are updated when incidents occur.

The surveyor verified the removal plan on site on 5/15/25 and determined the IJ for F657 was removed as of 5/15/25.

After the IJ removal plan, the non-compliance continued from 5/15/25 for no actual harm with the potential for more than minimal harm that is not an immediate jeopardy.

F689 K

Based on interviews, medical record reviews, and review of pertinent facility documentation on [redacted], it was determined that the facility failed to: A) ensure the residents' safety by failing to implement interventions to prevent drugs from entering the facility and [redacted] incidents from occurring while in the facility, B) conduct a thorough investigation into a resident's (Resident #6) [redacted], and C) notify the police and the New Jersey Department of Health (NJDOH) of the residents [redacted].

1. On 2/21/25 at approximately 6:30 PM, the [redacted] observed Resident #6 [redacted] in his/her wheelchair. Resident #6's [redacted] and he/she had [redacted]. The [redacted] stated she administered [redacted] to the resident. [redacted], the resident responded to the [redacted] and was sent to the hospital. On [redacted], Resident #6 returned to the facility from the hospital with a diagnosis of an [redacted].

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F 000	Continued From page 8 2. On 4/1/25, Resident #6 was found sitting in his/her wheelchair NJ Exec Order 26.4b1 . NJ Exec Order 26.4 , and he/she NJ Exec Order 26.4b1 . The doctor was notified, and the resident was sent to the hospital via 911. Resident #6 returned to the facility from the hospital with a diagnosis of NJ Exec Order 26.4b1 . 3. On 5/6/25, Resident #6 was NJ Exec Order 26.4b1 in his/her wheelchair outside his/her room during NJ Exec Order 26 . The resident was noted to have NJ Exec Order 26.4b1 in his/her NJ Exec Order 26.4b1 . The doctor was notified, and the resident was sent to the hospital. The U.S. FOIA (b)(6) stated that the U.S. FOIA (b)(6) gave Resident #6 NJ Exec Order 26 . According to the hospital Emergency Room (ER) documentation dated U.S. FOIA (b)(6) , the resident's diagnosis for the visit was NJ Exec Order 26.4b1 . The facility had knowledge that Resident #6 had a history of NJ Exec Order 26.4b1 and failed to implement interventions that ensured the residents' safety and prevent NJ Exec Order 26.4b1 from entering the facility. This resulted in Resident #6 having NJ Exec Order 26.4b1 while in the facility and being sent to the hospital for treatment of his/her symptoms. The facility failed to report Resident #6's U.S. FOIA (b)(6) that occurred while in the facility to the NJDOH and the local police. The facility's failure to protect Resident #6 from NJ Exec Order 26.4b1 placed Resident #6 and all other residents with a history of NJ Exec Order 26.4b1 in an Immediate Jeopardy (IJ) situation. The IJ began on NJ Ex Order 26.4 , was identified on 5/8/25 at 6:00 PM, and was reported to the U.S. FOIA (b)(6)	F 000		

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U.S. FOIA (b)(6) [redacted]. The U.S. FOIA (b)(6) was presented with the IJ template at that time.

An acceptable removal plan was electronically mailed to the surveyor on 5/13/25 at 4:23 PM, indicating the facility's actions to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice. The U.S. FOIA (b)(6) [redacted] provided education to all residents with a history of drug overdose on the medical risks with illegal drug use, police involvement, possible discharge from the facility, and revoking of facility leave privileges. Education was provided to the residents on cessation programs and psychiatric consultations. Signage was placed at the entrance of the facility stating that drugs and alcohol were not allowed in the facility. Facility staff were educated that any drug overdose is to be reported to the appropriate regulatory agencies immediately. Facility staff were educated on new interventions implemented to help prevent illegal drug use. These new interventions included education to the residents on the risks of a drug overdose, room searches, police involvement, possible discharge from the facility and revoking of facility leave privileges. The U.S. FOIA (b)(6) and the U.S. FOIA (b) implemented an audit process that occurred during the morning daily clinical meeting that will identify the residents with a new history of NJ Exec Order 2 use and any NJ Exec Or [redacted] that occur in the facility and that the police were called, and the appropriate regulatory agencies were notified.

The surveyor verified the removal plan on site on 5/15/25 and determined the IJ for F689 was removed as of 5/15/25.

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F 000	Continued From page 10 After the IJ removal plan, the non-compliance continued from 5/15/25 for no actual harm with the potential for more than minimal harm that is not an immediate jeopardy. F835K Based on interviews, medical record reviews, and review of other pertinent facility documentation on 5/8/25, it was determined that the facility's U.S. FOIA (b)(6) and administrative staff failed to ensure resident safety and well-being by failing to A) prevent NJ Exec O [redacted] from entering the facility and NJ Exec Order 26.4b1 incidents from occurring, B) ensure a thorough investigation was completed for a staff to resident NJ Exec Order 26.4b1 involving Resident #3 and NJ Exec Order 26.4b1 that occurred in the facility involving Resident #6, and C) ensure that the police and the New Jersey Department of Health (NJDOH) were notified of any NJ Exec O [redacted] that occurred in the facility. The facility's administrative staff failed to develop safety measures to ensure NJ Exec Order 26.4b1 were not used by its residents to prevent NJ Exec Order 26.4b1 [redacted] and ensure that thorough investigations were completed for a staff to resident NJ Exec Order 26.4b1. This placed all facility residents in an Immediate Jeopardy (IJ) situation. The IJ began on NJ Ex Order 26.4b [redacted] and was identified on 5/8/25 at 6:00 PM and was reported to the U.S. FOIA (b)(6) [redacted]. The U.S. FOIA (b)(6) [redacted] was presented with the IJ template at that time. An acceptable removal plan was electronically mailed to the surveyor on 5/13/25 at 4:23 PM, indicating the facility's actions to prevent serious	F 000		

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F 000	Continued From page 11 harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice. The Corporate Officer re-educated the [redacted] and the [redacted] on their job descriptions and the facility's policies on conducting a thorough investigation and the facility's elimination efforts on [redacted] at the facility. Signage was posted in the front of the building that no alcohol or drugs were allowed in the facility. The [redacted] or designee educated all facility staff on elimination of illicit drug use in the facility and to report any illicit drug use to the DOH and the police. The [redacted] and the [redacted] audited all incidents and accidents from January 2025 to ensure there were no additional unresolved allegations of abuse, neglect, and illicit drug use identified. The [redacted] implemented an audit process that occurred during the morning daily clinical meeting to assess potential abuse and any illicit drug activity and ensure these concerns were addressed per the facility policy. The surveyor verified the removal plan on site on 5/15/25 and determined the IJ for F835 was removed as of 5/15/25. After the IJ removal plan, the non-compliance continued from 5/15/25 for no actual harm with the potential for more than minimal harm that is not an immediate jeopardy.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		6/9/25

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TRENTON GARDENS REHABILITATION AND NURSING CENTER	**512 UNION STREET TRENTON, NJ 08611**

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F 584	Continued From page 12 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint # NJ 185458, NJ179424	F 584	F584 Safe/Clean/Comfortable/Homelike Environment	

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F 584	Continued From page 13 Based on observations, interviews, and review of other facility documentation on 5/7/2025, it was determined that the facility failed to maintain a clean and homelike environment for the residents. The deficient practice was identified for 2 of 3 units, (floor 2 and floor 4) and was evidenced by the following: During a tour of the 2nd floor unit on 5/7/2025 at 11:08 AM, the surveyor observed the following: 1. Inside 2nd floor "Central Bath," sink filled with isolation gown, black pad, wash sponge, and grey basin. 2. Inside 2nd floor "Central Bath," shower bed noted to have hair clippings, toilet paper, shaving cream can, a covered razor, a shampoo and a lotion bottle on it. 3. Inside 2nd floor "Central Bath," visible water on the floor outside of the shower stall and in the shower stall. 4. Inside 2nd floor "Central Bath" 1st stall, noted to have a brown hard substance to left outer dividing wall corner where the silver molding is missing. 5. Inside 2nd floor "Central Bath" 1st stall, brown, green, and black colored substance on bottom left corner of the shower where the walls meet and near grout. 6. Inside 2nd floor "Central Bath" 1st stall, build-up of brown and red color substance on the back left corner of the shower stall.	F 584	ELEMENT ONE: CORRECTIVE ACTION: • The second and fourth floor Central Baths were cleaned and sanitized by housekeeping on 5/9/25. • Noted black, brown, green, and red substances were removed from the second and fourth floor Central Baths on 5/9/25. • Personal hygiene and linen items were removed from the second-floor Central Bath sink on 5/9/25. • Hygiene and toiletries were removed from the second-floor Central Bath shower bed. • The molding in the 1st stall in the second-floor Central Bath was repaired on 6/7/25. • The build-up of unknown debris and hair in the 1st stall second-floor Central Bath shower was removed on 5/9/25. • Visible water on the floor inside and outside the second-floor Central Bath shower stall was removed on 5/9/25. • The housekeeping staff were re-educated in daily responsibilities to clean showers and to report any cleaning concerns to their director. • The nursing staff was re-educated to remove all personal items after showers on 6/9/25. • The maintenance staff was alerted to evaluate drainage in the second-floor shower. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: • All residents have the potential to be	

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F 584	Continued From page 14 7. Inside 2nd floor "Central Bath" 1st stall, wet towels and socks were noted to the back right corner of the shower stall. 8. Inside 2nd floor "Central Bath" 1st stall, noted to have a build-up of unknown debris and hair in the shower drain grate. 9. Inside 2nd floor "Central Bath" 2nd stall, brown, green, and black colored substance to the shower floor at entrance under curtain. 10. Inside 2nd floor "Central Bath" 2nd stall, brown, green, and black colored substance to the bottom corner of the shower where the walls meet and near grout. 11. Inside 2nd floor "Central Bath" 2nd stall, brown and black colored substance on the shower floor beside the silver middle strip. During a tour of the 4th floor unit 5/9/2025 at 11:13 AM, the surveyor observed the following: 1. Inside 4th floor "Central Bath"1st stall, green and black colored substance to the left corner of the shower stall where the walls meet. On 5/7/2025 at 11:10 AM, on the second-floor unit, an interview with License Practical Nurse (LPN) #3 was conducted by the surveyor. She stated that both shower stalls were in use and Certified Nurses Aids (CNA) were responsible for gathering belongings after the resident's shower. She further stated belongings should not be left in the sink or on the shower bed. LPN #3 stated that housekeeping staff were responsible for cleaning the shower room. The hard brown substance to	F 584	affected by this practice. ELEMENT THREE: SYSTEMIC CHANGES: • Leadership makes weekly rounds to check on cleanliness of showers. • The process for requesting maintenance work was reviewed and staff re-educated. • Maintenance and housekeeping issues are discussed at daily operation meeting • The Licensed Nursing Home Administrator reviews and acts upon issues reported. ELEMENT FOUR: QUALITY ASSURANCE: • Root cause analysis was conducted and a QAPI performance improvement project team formed to address maintenance and housekeeping concerns. The housekeeping director/nurse leadership designee will conduct weekly rounds to inspect the cleanliness, neatness, and functioning of showers. Maintenance will be notified to correct any repairs needed. Findings of rounds shall be reported to the Licensed Nursing Home Administrator weekly x 3 months. The findings and actions taken will be reported to the QAPI committee for review and further direction as appropriate. DATE OF COMPLIANCE : June 9, 2025	

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F 584	Continued From page 15 wall does not wash off. The [U.S. FOIA (b)] stated there should not have been belongings in the sink and there should not be debris on the shower bed. During an interview with the surveyor on 5/7/2025 at 11:20 AM, the U.S. FOIA (b)(6)) stated that the housekeeping staff were responsible for cleaning and disinfecting the shower rooms daily. The [U.S. FO] stated he was unsure of what the brown, green, and black substance was in the shower stalls. The [U.S. FO] was unsure of what the brown substance on the wall was and referred to the missing molding and maintenance as the cause. The [U.S. FO] was unsure of who is responsible for cleaning the shower grate. The [U.S. FO] stated the above findings did not create a homelike environment for the residents. During an interview with the surveyor on 5/9/2025 at 11:13 AM, the U.S. FOIA (b)(6) stated the showers are cleaned daily and is unsure what the black and green colored substance was. The [U.S. FO] stated the nursing staff are responsible for gathering belongings from shower area. The [U.S. FO] confirmed the above findings did not create a homelike environment for the residents. On 5/9/2025 at 12:03 PM, the U.S. FOIA (b)(6) in the presence of U.S. FOIA (b)(6) , the surveyor announced the above findings. The [U.S. FOIA (b)] conveyed she was not aware of any substance in the shower rooms and if there were, it should be addressed by housekeeping. The [U.S. FOIA (b)] confirmed the above findings would not create a homelike environment for the residents. On 5/9/2025 at 12:03 PM, The [U.S. FOIA (b)(6)] in the presence of the [U.S. FOIA (b)] stated the above findings	F 584		

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F 584	Continued From page 16 would not create a homelike environment for the residents. A review of the facility's undated housekeeping job description revealed, "Key Responsibilities: Cleaning and sanitation: perform cleaning and sanitizing of patient rooms, bathrooms, hallways, and common areas, and staff areas to maintain a safe, clean, and comfortable environment. This includes sweeping, moping, dusting, and vacuuming. Routine Inspections: Conduct regular inspections of the facility to ensure cleanliness standards are met and promptly address any areas requiring attention. Collaboration: Work closely with other team members, including nursing staff and management, to ensure that cleaning and sanitation needs are met in a timely manner, especially during high-traffic hours." A review of the facility's undated Director of Environmental services job description revealed, "The director of environmental services supervises a variety of activities in housekeeping and laundry in maintaining the facility in an orderly, clean, and sanitary condition ..."	F 584		
F 600 SS=J	NJAC 8:39-31.4 (a) (f) Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		6/9/25

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F 600	Continued From page 17 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Complaint # NJ182907 Based on interviews, medical record reviews, and review of other pertinent facility documentation on 5/7/25, 5/8/25 and 5/9/25, it was determined that the facility failed to ensure residents were protected from NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) when Resident #15 was observed to have NJ Exec Order 26.4b1 of unknown origin. The facility also failed to follow its policy titled, "Abuse, Resident Behavior and Facility Practice." On 10/12/24 at approximately 8:30 P.M, the U.S. FOIA was notified by the Licensed Practical Nurse (LPN) #6 that Resident #15 had a NJ Ex Order 26.4(b)(1). LPN #6 reported that Resident #8 left the room that he/she shared with Resident #15, U.S. FOIA (b)(6) he/she had U.S. FOIA (b)(6) (Resident #15). The U.S. FOIA failed to separate Resident #15 from Resident #8 who was NJ Exec Order 26.4b1. The facility failed to follow its policy titled, "Abuse, Resident Behavior and Facility Practice," and protect facility residents when the U.S. FOIA failed to immediately implement the NJ Ex Order 26 policy for the NJ Ex Order 26.4(b)(1) and to ensure both residents were immediately NJ Ex Order 26.4(b)(1) This placed Resident #15 and all residents in an Immediate	F 600	F600 *Free from Abuse and Neglect ELEMENT ONE: CORRECTIVE ACTION: • The U.S. FOIA (b)(6) received re-education by the corporate officer on job description and facilities policies on conducting a thorough investigation for NJ Exec Order 26.4b1 and the requirements to report these incidents to the DOH/police/LTCO on 5/9/25. • Resident #15 was evaluated for signs of NJ Exec Order 26.4b1 and none were noted. • The LPN involved in the incident involving Resident #8 and Resident #15 no longer works at the building. The U.S. FOIA caring for Residents #8 and Resident #15 on NJ Ex Order 26.4(b)(1) was re-educated on the abuse policy on 5/9/25. • The care plans of Residents #8 and #15 were reviewed and updated on 5/9/25. • The U.S. FOIA (b)(6) met with Resident #15 to support and offer a room change on NJ Exec Order 26.4b1 • Resident #8 and Resident #15's incident of NJ Exec Order 26.4b1 was reinvestigated by the U.S. FOIA (b)(6) on 5/9/25.	

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F 600	Continued From page 18 Jeopardy (IJ) situation. The IJ began on 10/12/24, was identified on 5/9/25 at 5:04 P.M., and was reported to the U.S. FOIA (b)(6)). The U.S. FOIA (b) was presented with the F600 IJ template at that time. An acceptable removal plan was electronically emailed to the surveyor on 5/13/25 at 4:24 P.M., indicating the facility's actions to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice. All facility staff were educated on the facility's policy abuse prevention, recognition of and types of abuse, reporting urgency and reporting to the regulatory agencies. The U.S. FOIA (b)(6) audited all incidents and accidents from 1/25 to 5/25, to assure there were no additional unresolved allegations of abuse identified. On 5/12/2025, the U.S. FOIA (b)(6) implemented an auditing process to assess potential abuse and ensure concerns are addressed through the policy. Auditing of all incidents/accidents will occur Monday through Friday, with weekend (Saturday and Sunday) incidents included in the Monday audit. The surveyor verified the removal plan on site on 5/15/25 at 3:10 P.M and determined the IJ for F600 was removed as of 5/15/25. After the IJ removal, the non-compliance continued from 5/15/25 for no actual harm with the potential for more than minimal harm that is not an immediate jeopardy. This deficient practice was identified for 1 of 18 residents (Resident #15) reviewed for NJ EX Order 2 and was evidenced by the following:	F 600	• The Director of Nursing / designee re-educated all nursing staff about the abuse policy on 5/9/25. • Incidents and accidents occurring from January 2025 through May 2025 were audited to ensure there were no identified, unresolved allegations of abuse and neglect on 5/12/25. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: • All residents have the potential to be affected by this practice. ELEMENT THREE: SYSTEMIC CHANGES: • Allegations of abuse are discussed at weekday clinical meetings and all concerns reported to the Licensed Nursing Home Administrator and Director of Nursing for follow up. • All residents were educated regarding the abuse policy at the resident council meeting held on 5/7/25 ELEMENT FOUR: QUALITY ASSURANCE: • Root cause analysis was conducted and a QAPI performance improvement project team formed to address clinical concerns. • Allegations of abuse are discussed at weekday clinical meetings and all concerns reported to the Licensed Nursing Home Administrator and Director of Nursing for follow up. • The Director of Nursing will report on	

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F 600	Continued From page 19 Record review showed no record of a Facility Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by healthcare facilities to report incidents. Record review revealed no investigation completed for this event on 10/12/24. According to the facility's "Grievance/Concern Communication Form," completed by the [U.S. FOIA (b)] with an event date of [NJ Exec Order 26.4b], under "Description of concern," "This writer met with Resident #15 this date. Nursing reported he/she had [NJ Exec Order 26.4b1]: [redacted] over the weekend. This writer observed some [NJ Exec Order 26.4b1]. Resident #15 insisted he/she does not know what happened. He/she [NJ Exec Order 26.4b1]. He/she did ask for a room change." Under "Grievance Officer Conclusion," Resident #15's [NJ Exec Order 26.4b1] on [NJ Exec Order 26.4b1] According to the Admission Record (AR), Resident #8 was admitted to the facility with diagnoses which included but were not limited to: [NJ Exec Order 26.4b1]. According to the Annual Minimum Data Set (MDS), an assessment tool dated [NJ Exec Order 26] Resident #8 had a Brief Interview for Mental Status (BIMS) score of [NJ Exe] which indicated the resident's [NJ Exec Order 26.4b1]. According to the AR, Resident #15 was admitted to the facility with diagnoses which included but were not limited to: [NJ Exec Order 26.4b1] [redacted] According to the Quarterly MDS, an assessment tool dated [NJ Exec Order 2], Resident #15 had a BIMS	F 600	audits of the daily meeting and any actions taken at the monthly Quality Assurance and Process Improvement Committee meetings x 3 months. Based on findings, a decision will be made regarding review and further directives. DATE OF COMPLIANCE : June 9, 2025	

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F 600	Continued From page 20 score of [redacted], which indicated the resident's [redacted]. A review of the Electronic Medical Record (EMR) revealed the following: Resident #8's Care Plan (CP) dated [redacted] included the following: Under "Focus" Resident #8 has a history of [redacted]. He/she is [redacted] Under "Goal" "Resident #8 will adjust to new facility." Under "Interventions" "Set limits and confront Resident #8's efforts in [redacted]. (Someone that [redacted] from [redacted] tend to exhibit [redacted] to [redacted]. Following through on the consequences of failure to maintain these limits is necessary for effective treatment.)" and "Staff will make in every attempt to meet his/her needs in a timely manner, if he/she becomes [redacted] or [redacted] staff will make sure he/she is safe in her/his surroundings & allow her/him space and time to [redacted]." A record review of the Progress Notes (PN) for Resident #8 revealed no documentation of the incident on [redacted]. There was no documentation in the PN to support that the facility implemented Resident #8's CP. On 5/9/25 at 12:02 P.M, during an interview with the[redacted] stated she was notified by the[redacted] that Resident #15 had a [redacted]. She was unable to state when she was notified by the [redacted]	F 600		

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F 600	Continued From page 21	F 600		

U.S. FOIA (b)(6) The U.S. FOIA (b) stated that "Resident #15 is alert and oriented but NJ Exec Order 26.4b1

On 5/9/25 at 12:25 P.M, during an interview with the U.S. FOIA, she stated LPN #6 told her that Resident #8 was NJ Exec Order 26.4b1 Resident #15 for NJ Exec Order 26.4b NJ Ex the bathroom. She stated that she was the supervisor 10/12/24 and she was called to assess Resident #15 after LPN #6 requested her to look at Resident #15's NJ Exec Orc. Upon assessment, Resident #15 had a NJ Exec Order 26.4b1 . The U.S. FOIA stated, "I asked Resident #15 if Resident #8 NJ Exec Order 26.4b1 and Resident #15 said . I asked Resident #15 if he/she NJ Ex Order 26.4(b and if he/she NJ Ex Order 26.4(b)(1) and he/she said no." The U.S. FOIA stated, "I notified my boss the U.S. FOIA (b)(6). I was asking U.S. FOIA (b) for guidance. I told her about the incident, if there was anything I needed to do, and she said no." When asked by the surveyor if this would be considered as NJ Ex Order 26.4 the U.S. FOIA stated she would consider this as NJ Exec Order 26.4b1 ." She also stated, "If NJ Ex Order 26 is suspected, NJ Ex Order 26.4(b)(1) , they should be NJ Ex Order 26.4(b)(1)

On 5/9/25 at 12:50 P.M., Resident #15 was interviewed and stated he/she remembered what led to her/his room change in NJ Exec Orde. Resident #15 stated that he/she spoke to the U.S. FOIA and told the U.S. FOIA that Resident #8 had U.S. FOIA (b)(6)

On 5/9/25 at 01:00 P.M, during an interview with the U.S. FOIA for Resident #15, she stated, "I did see NJ Exec Order 26.4b on Resident #15's NJ Exec Orc The NJ Exec Order 26.4b1 there was U.S. FOIA (b)(6)." She also stated that Resident #15 admitted to U.S. FOIA (b)(6) but denied that he/she was . When asked by the surveyor if she spoke to

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F 600	Continued From page 22	F 600		

Resident #15's roommate at the time, the [U.S. FOIA] stated, "No, I should have spoken to her/his roommate to see if there were any issues." When asked by the surveyor if the facility's abuse policy was followed, the [U.S. FOIA] stated, "Regarding the abuse policy, the policy was not followed. I should have spoken to his/her roommate to inquire if he/she knew anything about Resident #15's [NJ Exec Order 26]"

On 5/9/25 at 02:06 P.M, during a telephone interview with LPN #6 on 10/12/24 about Resident #8, she stated, "I heard Resident #8 saying he/she was [NJ Exec Order 26.4b1] Resident #15 [NJ Exec Order 26.4b1] and did not care." LPN #6 stated, "Resident #8 stated that they were tired of roommate (Resident #15) [NJ Exec Order 26.4b1] [redacted]." LPN #6 said she was not sure what Resident #8 was referring to, so she went to Resident #15's room and saw [NJ Exec Order 26.4b1] [redacted]. LPN #6 asked Resident #15 if Resident #8 had [redacted] her/him and Resident #15 said no. [U.S. FOIA (j)] #6 said she notified the supervisor about the incident. When asked by the surveyor if she spoke with Resident #8, LPN #6 stated, "No, I did not speak with Resident #8 to find out what had happened."

A review of the facility policy, implemented 5/93 and last revised 5/24, titled "Subject: Abuse, Resident Behavior and Facility Practice", revealed under "Policy," "The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, exploitation and involuntary isolation. No one may subject residents to abuse including, but not limited to facility staff, other residents, consultants, volunteers, staff or other agencies servicing the resident, family members or legal guardians,

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F 600	Continued From page 23 friends or other individuals." NJAC 8:39-4.1 (a) (5)	F 600		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #: NJ182907, NJ185458, NJ186028	F 609	F609 Reporting of Alleged Violations	6/9/25

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F 609	Continued From page 24 Based on interviews, medical record reviews, and review of other pertinent facility documentation on 5/7/25, 5/8/25, and 5/9/25 it was determined that the facility failed to: a.) report a to the New Jersey Department of Health (NJDOH) on [redacted] when Resident #15 was observed to have [redacted] b.) report to [redacted] when a resident (Resident #2) reported [redacted] between Licensed Practical Nurse (LPN #1) and another resident (Resident #3), and c.) report a [redacted] involving LPN #7 and Resident #1 to the NJDOH in a timely manner. The facility also failed to follow its policy titled "Abuse, Resident Behavior and Facility Practice." The deficient practice was evidenced by the following: A.) According to the facility's "Grievance/Concern Communication Form", filled out by the [redacted], with an event date of [redacted], revealed under "Description of concern", "This writer met with Resident #15 this date. Nursing reported he/she had [redacted] over the weekend. This writer observed some [redacted] Resident #15 insisted he/she does not know what happened. He/she [redacted]. He/she did ask for a [redacted]." Under "Grievance Officer Conclusion", it revealed Resident #15 ' s room was [redacted] on [redacted]. According to the Admission Record (AR), Resident #15 was admitted to the facility with diagnoses which included but were not limited to: [redacted].	F 609	ELEMENT 1 " The [redacted] and [redacted] received re-education by the corporate officer on job description and facilities policies on conducting a thorough investigation for [redacted] and the requirements to report these incidents to the DOH/police/LTCO on 5/9/25. " The Director of Nursing / designee re-educated all leadership staff about the abuse policy to include abuse prevention, recognition of and types of abuse, reporting urgency and reporting to the regulatory agencies. " Incidents and accidents occurring from January 2025 through May 2025 were audited to ensure there were no identified, unresolved allegations of abuse and neglect. " The New Jersey Department of Health, police and ombudsman were notified regarding the 10/12/24 incident between Residents #8 and #15. " The police was notified regarding the 4/25/25 incident between LPN #1 and Resident # 3. ELEMENT 2: " All residents have the potential to be affected by this practice. ELEMENT 3: " Allegations of abuse are discussed at weekday clinical meetings and all	

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F 609	Continued From page 25 According to the Quarterly MDS, an assessment tool dated [redacted], Resident #15 had a BIMS score of [redacted] which indicated the resident's [redacted] The facility was unable to provide the surveyors documentation that a Facility Reportable Event (FRE) was completed and submitted to the NJDOH for this event involving Resident #15. On 5/9/24 at 12:03 P.M, during an interview with the [redacted], the [redacted] stated, "I wouldn't consider it [redacted] a reportable event because Resident #15 is [redacted] and didn't recall how he/she got the [redacted]. When questioned whether [redacted] should be reported to the NJDOH, the [redacted] stated, '[redacted] should be reported to the NJDOH." The [redacted] also said, "We ([redacted]) are both responsible to investigate and report incidents." B.) According to the Facility Reportable Event Record (FRE), (a document used by health care facilities to report incidents to the New Jersey Department of Health) with an event date of "unknown" and a today's date of [redacted] revealed that Resident #2 came up to LPN #1 and told her that he/she was going to report her for [redacted] Resident #3. LPN #1 informed the [redacted] and was suspended immediately pending an investigation. The FRE did not indicate whether the [redacted] was made aware of the [redacted] involving LPN #1 and Resident #3. According to the AR, Resident #2 was admitted to	F 609	concerns reported to the Licensed Nursing Home Administrator and Director of Nursing for follow up. ELEMENT 4: QUALITY ASSURANCE: " Root cause analysis was conducted and a QAPI performance improvement project team formed to address clinical concerns. " Allegations of abuse are discussed at weekday clinical meetings and all concerns reported to the Licensed Nursing Home Administrator and Director of Nursing for follow up. " The Director of Nursing will report on audits of the daily meeting and any actions taken at the monthly Quality Assurance and Process Improvement Committee meetings x 3 months. Based on findings, a decision will be made regarding review and further directives. Date of Completion: June 9, 2025	

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F 609	Continued From page 26	F 609		

the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted]

According to the Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident's NJ Exec Order 26.4b1

According to the AR, Resident #3 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted]

According to the Quarterly MDS, and assessment tool dated [redacted] Resident #3 had a BIMS score of [redacted] which indicated the assessment could not be completed. The MDS further revealed the resident was NJ Exec Order 26.4b1 [redacted]

On 5/7/25 at 2:30P.M., the surveyor interviewed the U.S. FOIA (b)(6) [redacted]). The [redacted] stated "I would notify [redacted] of any NJ Exec Order 26.4b1. No, I did not notify [redacted] because I felt it was not substantiated."

C.) According to the FRE, with an event date of [redacted] and today's date of 3/3/25, Resident #1 told the U.S. FOIA (b)(6) and the Ombudsman on [redacted] that LPN #7 spoke to him/her NJ Ex Order 26.4(b)(1) on [redacted]. The resident stated that the nurse told him/her that he/she had a [redacted]. The FRE further indicated this event was called into the NJDOH on 3/3/25 at 1:45 PM.

According to the AR, Resident #1 was admitted to the facility in U.S. FOIA (b)(6) with diagnoses

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F 609	Continued From page 27 which included but were not limited to: [redacted].	F 609		

According to the Quarterly MDS, an assessment tool dated [redacted], the resident had a BIMS score of [redacted], which indicated the resident's [redacted].

On 5/7/25 at 2:30 PM, the surveyor interviewed the [redacted] who confirmed that according to the FRE the [redacted] between Resident #1 and LPN #7 was reported to the NJDOH on 3/3/25. The [redacted] stated that an [redacted] was supposed to be reported to the DOH within an hour. The [redacted] further stated " I can't give you an answer to why it was reported on March 3. Yes, it should have been reported to the DOH sooner because it is the regulation."

A review of the facility's policy titled "Abuse, Resident Behavior and Facility Practice" with a revised date of 5/24 revealed under "Reporting", "1. The Director of Nursing/Administrator /designee will report to the Department of Health and Ombudsman program according to regulatory requirements if there is reason to suspect abuse, neglect or mistreatment. Reporting will also include any incident which result in an adverse event. 6. All appropriate law enforcement agencies will be notified of any allegations of abuse or neglect according to required timeframes. 7. All appropriate regulatory agencies will be notified of any allegations of abuse and neglect according to required timeframes."

NJAC 8.39-9.4

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F 610	Continued From page 28	F 610		
F 610 SS=K	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #: NJ182907, NJ186028 Based on interviews, medical records reviews, and review of other pertinent facility documentation on NJ Exec Order 26.4b1 it was determined that the facility failed to complete thorough investigations when A) Resident #15 was observed to have NJ Exec Order 26.4b1 . B) when a resident reported witnessing an NJ Exec Order 26.4b1 between another resident (Resident #3) and the Licensed Practical Nurse (LPN #1). The facility also failed to ensure its policy titled "Abuse, Resident Behavior and Facility Practice" was implemented for the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) .	F 610	F610 *Investigate/Prevent/Correct Alleged Violation ELEMENT ONE: CORRECTIVE ACTION: • The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) received re-education by the corporate officer on job description and facilities policies on conducting a thorough investigation for NJ Exec Order 26.4b1 and the requirements to report these incidents to the DOH/police/LTCO on NJ Exec Order 2. • The Licensed Nursing Home Administrator and Director of Nursing re-educated the U.S. FOIA (b) (6) and all	6/9/25

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F 610	Continued From page 29 1. On 10/12/24 at approximately 8:30 P.M, the U.S. FOIA (b)(6) was notified by LPN #6 that Resident #15 NJ Exec Order 26.4b1. LPN #6 reported that Resident #8 left the room that he/she shared with Resident #15 NJ Exec Order 26.4b1 he/she NJ Exec Order 26.4b1 resident (Resident #15). The U.S. FOIA (b) failed to conduct a thorough investigation. The U.S. FOIA (b) stated that Resident #15 was NJ Exec Order 26.4b1 roommate (Resident #8). The NJ Exec Ord also said, "I spoke with both of them (Resident #8 and Resident #15) but they NJ Exec Or that Resident #15 was NJ Exec No follow-up investigation was conducted outside of the grievance filed for Resident #15." The facility failed to follow its policy titled, "Abuse, Resident Behavior and Facility Practice" and protect facility residents when the U.S. FOIA (b) failed to immediately implement the abuse policy for the NJ Ex Order 26.4(b)(1) and to conduct a thorough investigation for the NJ Ex Order 26.4(b)(1). This placed Resident #15 and all residents in an Immediate Jeopardy (IJ) situation. The IJ began on 10/12/24, was identified on 5/9/25 at 5:04 P.M. At this time, the IJ Template was presented to the U.S. FOIA (b) An acceptable removal plan was electronically emailed to the surveyor on 5/13/25 at 4:24 P.M., indicating the facility's actions to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice. All the facility staff were educated on the facility's policy abuse-prevention, recognition of and types of abuse, reporting urgency and reporting to the regulatory agencies. TheU.S. FOIA (b)(6) audited all	F 610	nursing staff on the abuse policy to include reporting abuse and conducting a thorough investigation on NJ Exec Order 26 • The resident-to-resident NJ Exec Order 2 involving Resident #8 and Resident #15 on NJ Exec Order 26.4b1 was reinvestigated by the on NJ Exec Order 2. • The NJ Ex Order 26.4(b)(1) involving LPN #1 and Resident #3 on 4/25/25 was reinvestigated by the U.S. FOIA (b)(6) to include interviews with residents on LPN #1's work assignment and witness statements from staff 5/8/25. • Incidents and accidents occurring from January 2025 through May 2025 were audited to ensure there were no identified, unresolved allegations of abuse and neglect. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: • All residents have the potential to be affected by this practice. ELEMENT THREE: SYSTEMIC CHANGES: • Allegations of abuse are discussed at weekday clinical meetings and all concerns reported to the Licensed Nursing Home Administrator and Director of Nursing for follow up. • All residents are educated about abuse policy at Resident Council meetings. ELEMENT FOUR: QUALITY	

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F 610	Continued From page 30 incidents and accidents from 1/25 to 5/25, to assure there were no additional unresolved NJ Ex Order 26.4(b)(1) identified. On 5/12/2025, the U.S. FOIA (b)(6) implemented an auditing process to assess potential NJ Ex Order 26 and ensure concerns are addressed through the policy. Auditing of all incidents/accidents will occur Monday through Friday, with weekend (Saturday and Sunday) incidents/accidents included in the Monday audit. 2. On 4/25/25, Resident #2 told LPN #1 that he/she was going to NJ Exec Order 26.4b1 Resident #3. LPN #1 reported this immediately to the U.S. FOIA (b)(6) and LPN #1 was suspended. The U.S. FOIA (b) stated that Resident #2 informed her on NJ Exec Order 26.4b that the NJ Exec Order 26.4b1 with LPN #1 and Resident #3 had occurred three weeks prior and then later stated the incident occurred six weeks ago. The U.S. FOIA (b) stated she conducted an investigation and suspended LPN #1 immediately after the NJ Exec Order 26.4b1 was reported to her. The U.S. FOIA (b) stated she did not conduct interviews or assessments for residents on LPN #1's assignment and did not obtain witness statements from other staff that worked on the unit when the NJ Exec Order 26.4b1 was made. The facility failed to follow its policies and procedures and protect the facility residents by not conducting a thorough investigation into whether other residents or staff members had any reports of NJ Ex Order 26.4(b)(1) involving LPN #1. This placed the residents being cared for by this staff member in an immediate jeopardy (IJ) situation. The IJ began on NJ Ex Order 26.4(b)(1 was identified on 5/8/25 at 6:00 P.M., and was reported to the U.S. FOIA (b)(6)). The U.S. FOIA (b)(6) was presented with the IJ template at	F 610	ASSURANCE: • Root cause analysis was conducted and a QAPI performance improvement project team formed to address clinical concerns. • Allegations of abuse are discussed at weekday clinical meetings and all concerns reported to the Licensed Nursing Home Administrator and Director of Nursing for follow up. • The Director of Nursing will report on audits of the daily meeting and any actions taken at the monthly Quality Assurance and Process Improvement Committee meetings x 3 months. Based on findings, a decision will be made regarding review and further directives. DATE OF COMPLIANCE : June 9, 202	

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F 610	Continued From page 31 that time. An acceptable removal plan was electronically mailed to the surveyor on 5/13/25 at 4:23PM, indicating the facility's actions to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice. On 5/8/25, the residents that were on LPN #1's schedule were interviewed and assessed for any complaints of inappropriate behaviors requested or witnessed by LPN #1. On 5/9/25, the U.S. FOIA (b)(6) educated the social workers (SW) and administrative nursing staff on the facility's policy on reporting of abuse and conducting a thorough investigation. The U.S. FOIA (b)(6) conducted an investigation into incidents and accidents from NJ Ex Order 26.4(b)(1). On 5/12/2025, the U.S. FOIA (b)(6 implemented an auditing process to assess potential NJ Ex Order 26 and ensure concerns are addressed through the policy. Auditing of all incidents/accidents will occur Monday through Friday, with weekend (Saturday and Sunday) incidents/accidents included in the Monday audit. The surveyor verified the removal plan on site on 5/15/25 and determined the IJ for F610 was removed as of 5/15/25. After the IJ removal plan, the non-compliance continued from 5/15/25 for no actual harm with the potential for more than minimal harm that is not an immediate jeopardy. This deficient practice was identified for 4 of 18 residents (Resident #2, Resident #3, Resident #8, and Resident #15) reviewed and was evidenced by the following:	F 610		

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F 610	Continued From page 32 According to the Facility Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by healthcare facilities to report incidents with an event date of "unknown" and a today's date of 4/25/2025 revealed that Resident #2 came up to LPN #1 and told her that he/she was going to report her for [redacted] with Resident #3. LPN #1 informed the [redacted] and was suspended immediately pending an investigation. A review of the medical records for Resident #2 and #3 indicated the following: Resident #2 was admitted to the facility with diagnoses which included but were not limited to: [redacted]. According to the Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident's [redacted]. Resident #3 was admitted to the facility with diagnoses which included but were not limited to: [redacted]. According to the Quarterly MDS, and assessment tool dated [redacted], Resident #3 had a BIMS score of [redacted] which indicated the assessment could not be completed. The MDS further revealed the resident was [redacted]. On 5/7/25 at 10:17 AM, the surveyor interviewed Resident #2, who stated he/she went into the hallway at 3:00 AM and observed the medication	F 610		

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cart in front of Resident #3's room. Resident #2 could not provide the surveyor with the exact date the NJ Ex Order 26.4(b)(1) occurred. Resident #2 stated he/she waited about half an hour for LPN #1 to come out Resident #3's room. Resident #2 then went back to his/her room for a brief period and then returned to the hallway. Resident #2 stated he/she still observed the medication cart in front of Resident #3's room. Resident #2 stated he/she pushed the medication cart and went into Resident #3's room and observed LPN #1 pull the NJ Exec Order 26.4b1 Resident #3's NJ Exec Or Resident #2 stated he/she observed Resident #3 with an NJ Exec Order 26.4b. Resident #2 further indicated he/she asked LPN #1 what she was doing. The resident stated that the LPN #1 told him/her that she was giving medical attention to Resident #3. Resident #2 indicated he/she reported the NJ Ex Order 26.4(b)(1) the next day to the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) but was unsure of the U.S. FOIA (b) (6) name.

On 5/7/25 at 2:30 PM, the surveyor interviewed the U.S. FOIA (b) who stated that on NJ Exec Order 26.4, LPN #1 reported to the supervisor that Resident #2 had NJ Exec Order 26.4b1 Resident #3. The U.S. FOIA (b) stated she immediately suspended LPN #1 pending an investigation. The U.S. FOIA (b) stated she spoke with Resident #2, and he/she stated that LPN #1 NJ Exec Order 26.4b1 Resident #3. She further stated she asked him/her when the incident occurred, and Resident #2 stated NJ Ex Order 26.4(b)(1) ago and then changed it to NJ Ex Order 26.4(b)(1) ago. The U.S. FOIA (b) indicated she conducted a NJ Ex Order 26.4(b) assessment on Resident #3 and interviewed Resident #2, LPN #1, the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) The U.S. FOIA (b) stated "No, I

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did not speak to any residents she (LPN #1) cared for. No, I did not speak to any other staff members. I felt the people I spoke with gave me an honest report." The [U.S. FOIA (b)] indicated that in the past she had collected resident and staff statements but denied collecting them for this incident. The [U.S. FOIA (b)] further stated "If I feel it is warranted, I would interview the residents. I did not feel it was warranted because I did not have a time frame of when the allegation occurred. I didn't interview other staff because I did not have a timeframe of when the incident happened."

On 5/8/25 at 4:29 PM, the surveyor interviewed the [U.S. FOIA (b)(6)] who stated that a thorough investigation should be conducted for all [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b)(6)] further indicated "All residents on a staff member's assignment for an [NJ Ex Order 26] should be interviewed." The [U.S. FOIA (b)(6)] stated that the staff working when the [NJ Exec Order 2] occurred should have been interviewed as well.

On 5/8/25 at 4:42 PM, the surveyor conducted a follow-up interview with the [U.S. FOIA (b)]. The [U.S. FOIA (b)] stated there has never been an [NJ Ex Order 26.4(b)(1)] in past involving LPN #1.

The surveyor left a voicemail message for LPN #1 on 5/8/2025 and LPN #1 did not return the surveyor's phone call.

A review of the medical records for Resident #8 and #15 indicated the following:

Resident #8 was admitted to the facility with diagnoses which included but were not limited to: [NJ Exec Order 26.4b1].

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F 610	Continued From page 35 According to the Annual MDS, dated [NJ Exec Order 26] Resident #8 had a BIMS score of [NJ Exec] which indicated the resident's NJ Exec Order 26.4b1. Resident #15 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 According to the Quarterly MDS, an assessment tool dated [NJ Exec Order 26], Resident #15 had a BIMS score of [NJ Exec] which indicated the resident's NJ Exec Order 26.4b1. On 5/9/25 at 12:02 P.M, during an interview with the [U.S. FOIA (b)] and the U.S. FOIA (b)(6) stated, "I spoke with Resident #8 on the day I found out about the incident. I thought I wrote that on the incident report, but I guess I didn't." When the surveyor asked if an investigation was conducted, the [U.S. FOIA (b)] said, "I spoke with both of them (Resident #8 and Resident #15) but they both denied that Resident #15[NJ Exec Order 26]. No follow up investigation was conducted outside of the grievance filed for Resident #15." When the surveyor asked the [U.S. FOIA (b)] if she spoke to witnesses, she stated, "I spoke to staff but I didn't document. Nobody had witnessed any [NJ Ex Order 26.4(b)(1)] Speaking with staff I should have documented and collected witness statements. Our policy was not followed." The U.S. FOIA (b)(6) both acknowledged a thorough investigation was not completed for the physical abuse and their policy was not followed. A review of the facility's policy titled "Abuse, Resident Behavior and Facility Practice" with a revised date of 5/24 revealed under "Purpose", "To ensure timely and thorough investigation of abuse, neglect, and/or mistreatment of residents."	F 610		

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F 610	Continued From page 36 Under "Investigation," "3. The DON/designee: a. Review the accident/incident report; b. Obtains written statements of staff assigned to the Resident for: i. the shift during which the allegation is noted; ii, a minimum of 16 hours prior to the incident if indicated or appropriate; c. Interview witnesses, in any; d. Reviews the Resident's record; e. Reviews staff assignments and staff performance; f. Corrective action is taken including but not limited to progressive counseling, education, increased supervision, up to and including termination as appropriate; g. Polices are re-evaluated and revisited if necessary to prevent recurrences; h. Reports findings to the Administrator." NJAC 8:39-9.3 (a)	F 610		
F 627 SS=D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)(iv) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered;	F 627		6/9/25

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F 627	Continued From page 37 (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)	F 627		

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F 627	Continued From page 38 (i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility;	F 627		

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and
(B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services
(ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.

§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.

§483.21(c)(1) Discharge Planning Process
The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be

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updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent

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F 627	Continued From page 41 the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Complaint #NJ184250 Based on interview and record review it was determined that the facility failed to appropriately discharge a resident from the facility. This	F 627	F627 Inappropriate Discharge ELEMENT 1 • The Director of Nursing reviewed the	

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F 627	Continued From page 42 deficient practice was identified for 1 of 18 residents who was discharged without a 30-day discharge notice. This deficient practice was evidenced by the following: According to Resident #16's Admission Record (AR), the resident was admitted with diagnoses that included but were not limited to: [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #16 had a Brief Interview of Mental Status (BIMS) score of [redacted], which indicated the resident was [redacted] On 5/8/25 at 12:26 P.M, during an interview with the Social Worker (SW #2) she stated, "Resident #16 had an incident with her/his roommate which led to a [redacted]. Resident #16 didn't return back to the facility because it was [redacted] and the roommate [redacted] her/him back. Resident #16's [redacted] was notified via phone call by [redacted]) that he/she would [redacted]. Resident #16 ended up in a [redacted] and then the [redacted]." When the surveyor asked SW #2 if she would consider this a safe discharge she said, [redacted]. It's safe because he/she had nowhere else to go." On 5/8/25 at 12:46 P.M, during an interview with SW #1 the surveyors asked if Resident #16 was refused readmission after the incident. SW #1 stated, "We don't have the authority to refuse a	F 627	discharge documentation of Resident #16 and clarified the actions taken by [redacted] regarding the disposition of Resident #16. • A clarifying note was also placed in the chart of Resident #16 regarding the actions taken by [redacted]. • Per the direction of [redacted] all needed physician orders and medications were provided to [redacted] who [redacted] Resident # 16 into their custody and placed the resident in a safe location with medical staff available to provide care. The family and physician were notified of the [redacted] actions. • Social work and all nursing staff received re-education about 30-day notice of discharge and safe discharge. ELEMENT 2 • All residents have the potential to be affected by this practice. ELEMENT 3 • The policy for discharge when necessary was reviewed and updated as appropriate by the Licensed Nursing Home Administrator and Director of Nursing. • The Director of Nursing re-educated leadership on documentation of discharge when necessary. • Discharges occurring from January 2025 through May 2025 were audited to ensure that there were no other occurrences of discharge when	

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F 627	Continued From page 43 resident as social workers. Refusing to have them (residents) back, that's up to admission and administration." On 5/8/25 at 1:44 P.M, during an interview with the [U.S. FOIA (j)] she said, "Resident #16 [NJ Exec Order 26.4b1] a resident, so we decided NJ Ex Order 26.4(b)(1) . I spoke to Resident #16's [NJ Exec Orde] and notified her. Resident #16 had a NJ Exec Order 26.4b1. The [NJ Exec Orde] was disappointed because we were working on discharging Resident #16 to a group home." When the surveyor asked the [U.S. FOIA (j)] if she would consider this a safe discharge she stated, "I do consider it a safe discharge because we gave all of Resident #16's meds and electronic Medication Administration Record (eMAR) to the [NJ Ex Order 26] as he/she left. I didn't think Resident #16 would be returning when he/she left with the [NJ Ex Order 26.4(b)] Record review showed no documented evidence that a 30-day advanced notification was given to Resident #16 or her/his responsible party. NJAC 8:39-4.1(32)	F 627	necessary. ELEMENT 4 • Root cause analysis was conducted and a QAPI performance improvement project team formed to address discharge concerns. The Social Worker reports on discharges monthly. Findings shall be reported to the Licensed Nursing Home Administrator weekly x 3 months. The findings and actions taken will be reported to the QAPI committee for review and further direction as appropriate. Date of Completion: June 9, 2025	
F 657 SS=J	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		6/9/25

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F 657	Continued From page 44 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Complaint #: NJ185458 Based on interviews, medical record reviews, and review of other pertinent facility documentation on NJ Exec Order 26 it was determined that the facility failed to a.) update the care plan (CP) with interventions for a resident (Resident #6) who had NJ Exec Order 26.4 incidents while at the facility and b.) follow the facility's policy titled "Policy on Resident Care Planning." On 2/21/25 at approximately 6:30 PM, the U.S. FOIA (b)(6) observed Resident #6 NJ Exec Order 26.4b1 in his/her wheelchair. Resident #6's NJ Exec Order 26.4b1), and he/she had NJ Exec Order 26.4b1. The U.S. F stated she NJ Exec Order 26.4b1 to the resident. NJ Exec Order 26.4b1 , the resident NJ Exec Order 26.4b1 and was sent to the hospital. On NJ Exec Order 26.4b, Resident #6 returned	F 657	F657 Care Plan Timing and Revision ELEMENT ONE: CORRECTIVE ACTION: • The care plan of Resident #6 was reviewed and updated to reflect history and potential risk of NJ Exec Order 26.4b1 . • The staff caring for Resident #6 were educated on the updates to the care plan. • The Director of Nursing / designee re-educated the nursing administrative team and U.S. FOIA (b) (6) on the resident care plan policy. • An audit of the care plans of residents with history and/or potential risk of NJ Ex Ord or NJ Ex Order 26.4(b)(1) was conducted and care plans updated as needed. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS:	

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	315324	A. BUILDING _____ B. WING _____	C 05/15/2025

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F 657	Continued From page 45 to the facility from the hospital with a diagnosis of NJ Exec Order 26.4b1. On NJ Exec Order 2, the resident was found sitting in his/her wheelchair NJ Exec Order 26.4b1 Multiple attempts were made to NJ Exec Order 26, and he/she NJ Exec Order 26.4b1 The doctor was notified, and the resident was sent to the hospital via 911. Resident #6 returned to the facility from the hospital with a diagnosis of NJ Exec Order 26.4b1. On NJ Exec Order 2, the resident was NJ Exec Order 26.4b1 in his/her wheelchair NJ Exec Order 2 The resident was noted to have NJ Exec Order 26.4b1 in his/her NJ Exec Order 26.4b1. The doctor was notified, and the resident was sent to the hospital. The U.S. FOIA (b)(6) stated that the U.S. FOIA (b)(6) gave Resident #6 NJ Exec Order 26.4b According to the hospital Emergency Room (ER) documentation dated NJ Exec Order 2, the resident's diagnosis for the visit was NJ Exec Order . The facility did not update Resident #6's CPs to manage the resident's NJ Exec Order 26.4b1 after the resident NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 The facility's failure to update the CP with interventions for Resident #6 to prevent further NJ Exec Order 26.4b1 placed all residents in an Immediate Jeopardy (IJ) situation. The IJ began on NJ Ex Order 26.4(, was identified on 5/8/25 at 6:00 PM., and was reported to the U.S. FOIA (b)(6)). The U.S. FOIA (b)(6) was presented with the IJ template at that time. An acceptable removal plan was electronically mailed to the surveyor on 5/13/25 at 4:23 PM, indicating the facility's actions to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to	F 657	• All residents have the potential to be affected by this practice. ELEMENT THREE: SYSTEMIC CHANGES: • Residents with incidents of illicit drug abuse and/or overdose will be discussed and care plans updated at weekday clinical meetings. ELEMENT FOUR: QUALITY ASSURANCE: • Root cause analysis was conducted and a QAPI performance improvement project team formed to address clinical concerns. • Illicit drug abuse and /or overdose are discussed at weekday clinical meetings and all concerns reported to the Licensed Nursing Home Administrator and Director of Nursing for follow up. • The Director of Nursing will report on audits of care plans the weekday clinical meeting and any actions taken at the monthly Quality Assurance and Process Improvement Committee meeting committee x 3 months. Based on the results of these audits, a decision will be made regarding review and further direction as appropriate. DATE OF COMPLIANCE : June 9, 2025	

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F 657	Continued From page 46	F 657		

remediate the deficient practice. On 5/8/25, Resident #6's care plan was updated. On 5/9/25, the U.S. FOIA (b)(6) educated the administrative nursing staff and social workers (SW) were educated on updating and implementing care plans when incidents occur. The U.S. FOIA (b) implemented a process to occur during daily morning clinical meeting to ensure that care plans were updated when incidents occur.

The surveyor verified the removal plan on site on 5/15/25 and determined the IJ for F657 was removed as of 5/15/25.

After the IJ removal plan, the non-compliance continued from 5/15/25 for no actual harm with the potential for more than minimal harm that is not an immediate jeopardy.

This deficient practice was identified for 1 of 3 residents (Resident #6) reviewed for care plans and evidenced by the following:

According to the Admission Record (AR), Resident #6 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1

According to the Quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 2, Resident #6 had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1.

A review of Resident #6's PN dated NJ Exec Order 26.4b revealed the U.S.F was called into the resident's room NJ Exec Order 26.4b1 by staff. The resident was

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F 657	Continued From page 47 NJ Exec Order 26.4b1 in his/her wheelchair with U.S. FOIA (b)(6). The resident's NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 The resident was transferred to the hospital. A review of Resident #6's Emergency Department Documentation (EDD) with a visit date of NJ Exec Order 26. revealed under "Diagnosis from Today's Visit," NJ Exec Order 26.4b1 ." A review of the PN dated revealed that Resident #6 was found sitting in his/her wheelchair and NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 The doctor was notified, and the resident was NJ Ex Order 26.4(b)(1) The resident returned from the hospital and was treated for an U.S. FOIA (b)(6) A review of Resident #6's EDD with a visit date of NJ Exec Order 26. revealed under "Diagnosis from Today's Visit," NJ Exec Order 26.4b1 ." A review of the PN dated NJ Exec Order 26. completed by the revealed that during rounds Resident #6 was noted to be NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 was noted to the resident's U.S. FOIA (b)(6) The doctor was notified, and a new order given to send to hospital for change in NJ Exec Order 26.4b1 and the resident was sent to the NJ Exec Order 26.4b1 A review of Resident #6's EDD with a visit date of U.S. FOIA (b)(6) revealed under "Diagnosis from Today's Visit," NJ Exec Order 26.4b1 ." A review of Resident #6's CP revealed a "Focus"	F 657		

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F 657	Continued From page 48 revised on NJ Exec Order 26.4b1 that "Resident #6 had a history of NJ Exec Order 26.4b1. Admitted to using NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. NJ Ex Order 26.4(b)(1) Resident #6 had an incident here where he/she was sent to the NJ Exec Order 26.4b1 possibly due to NJ Exec Order 26.4b1 " Resident #6's CP revealed no updated CP interventions after the resident NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 On 5/8/25 at 10:33 AM, the U.S. FOIA (b)(6) stated that the care plans were updated after an incident occurred such as NJ Exec Order 26.4b1, or any unusual change occurred. The U.S. FOIA (b)(6) stated that she thought that Resident #6's care plans had been updated but she would have to check into it. On 5/8/25 at 2:35 PM, the surveyor interviewed the U.S. FOIA (b)(6)) who acknowledged that Resident #6's care plan interventions were not updated after the resident's NJ Exec Order 26.4b1 . The U.S. FOIA (b) stated that the care plan interventions that were already in place for the resident were appropriate for his/her NJ Exec Order 26.4b1 and did not need to be updated after the NJ Exec Order 26.4b1 occurred. The U.S. FOIA (b) further stated "Obviously, the interventions didn't work if he/she had another NJ Exec Order 26.4b1 The U.S. FOIA (b) indicated that the care plans were updated when there is a change in condition or a significant event. The U.S. FOIA (b) stated "Yes, the care plan should have been updated." The U.S. FOIA (b) further indicated that it was important to update the care plans because it gives an accurate picture of the resident.	F 657		

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F 657	Continued From page 49 On 5/8/25 at 4:16 PM, the surveyor conducted a follow-up interview with the [redacted]. The [redacted] stated that the expectation was that the care plans should be updated the first business day after an incident occurred. The [redacted] indicated that the [redacted] were responsible for updating the resident care plans. The [redacted] further indicated "I think it wasn't updated because we as a team felt he/she had everything in place." A review of the facility's policy titled "Policy on Resident Care Planning" dated June 2024 revealed under "Purpose", "The main purpose of the Care Plan is the resident's quality of life and safety and updated with any changes in diagnosis or condition." Under "Procedure", "2. The care plan will be reviewed and updated by the unit manager and other departments as changes in the resident occur. 3. The Care Plan is updated as warranted by the resident's changes and preferences." NJAC 8:39-11.2 (e) (1) (2)	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: C#175920 Based on interviews, medical record reviews, and	F 658	F658 Services Provided Meet Professional Standards	6/9/25

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F 658	Continued From page 50 other pertinent facility documentation on [redacted], [redacted], and [redacted], it was determined that the facility failed to follow a Physician's Order (POs) for a treatment to the Resident's (Resident #5) [redacted] The facility also failed to follow its policies titled " P&P Physician Order" and "Medication Administration Policy and Protocol." This deficient practice was identified for 1 of 18 residents and was evidenced by the following: Reference: "The practice of nursing as a Licensed Practical Nurse is defined as performing tasks, and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a Registered Nurse, or otherwise legally authorized Physician or Dentist." A review of the Electronic Medical Record (EMR) was as follows: According to the "Admission Record (AR)," Resident #5 was admitted to the facility with diagnoses which included but were not limited to: [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #2 had a Brief Interview of Mental Status (BIMS) score of [redacted], indicating the resident was [redacted]. The MDS also showed the resident needed [redacted] with Activities of Daily Living (ADLs).	F 658	ELEMENT 1 • The staff caring for Resident #5 on days 7/6,7/7, 7/20, 7/25, and 7/31/ 24 were re-educated on physician order and medication administration policies on documentation. • Staff was re-educated to follow up with notification to medical provider and document when treatments are not performed. ELEMENT 2 • All residents have the potential to be affected by this practice. ELEMENT 3 • Leadership staff are educated on use of the Point click care dashboard to track missing medication and treatment signatures. • Staff are directed by nurse leadership to complete electronic treatment record documentation before the end of shift. ELEMENT 4 • Root cause analysis was conducted and a QAPI performance improvement project team formed to address discharge concerns. • The Director of Nursing / designee audits numbers of missed documentation monthly. Findings shall be reported to the Licensed Nursing Home Administrator x 3 months. The findings and actions taken will be reported to the QAPI committee for	

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F 658	Continued From page 51 Review of the "Order Summary Report (OSR)" for Resident #2 dated [redacted] included the following Physician's Order (PO's): [redacted] Apply to [redacted] every day shift for [redacted] pat dry, apply [redacted] and [redacted] with [redacted]. Review of the Treatment Administration Record (TAR) for Resident #5 dated [redacted] showed medication and treatment was not administered for the [redacted] on July 6,7,20,25,31 of 2024. A review of Resident #2's Progress Notes (PNs) for the month of [redacted] PNs showed no documentation that the resident's Physician was notified of the above-missed doses of medication and treatment. During the survey, the [redacted] who failed to administer the above medications as ordered by the Physician were not available for interview. During an interview on 5/7/2025 at 2:02 p.m., the [redacted] of the [redacted] floor where Resident #5 resides stated, "Regarding [redacted] should be done per orders. I'd sign the TAR and document. A blank means that it wasn't done. My expectation for the nurses on my unit is to follow the orders and then document on the TAR and to notify the doctor and nurse practitioner if necessary for changes to the [redacted] That's the facility's policies. If a patient refuses, expectation is to document the refusal in the TAR as well.	F 658	review and further direction as appropriate. Date of Completion: June 9, 2025	

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LPN #4 called the surveyor, and a phone interview was conducted on 5/7/2025 at 2:05 P.M. LPN #4 stated, "We do [redacted] per orders. I document how the wound looks on the TAR. I would document a refusal and sign TAR. No blanks on TAR. If it's not documented, it meant it's not done, and I need to sign to let others know care was provided. If it's blank, it's considered not done and it's not following the facility's policy."

LPN #5 called the surveyor, and a phone interview was conducted on 5/7/2025 at 2:14 P.M. LPN #5 stated, "If you don't document you didn't do it. If they refuse, document it on TAR. There should be no blanks on the TAR. Blanks mean it's not done. It's important to document to make sure treatment is being done so NJ Ex Order 26.4(b)(1). If there are empty spots facility policy wasn't followed."

During an interview on 5/7/2024 at 2:55 p.m., the Surveyor asked the U.S. FOIA (b)(6) the expectation of her nurses for NJ Exec Order 26.4b1 medication, and treatment orders. The U.S. FOIA (b) stated, "My expectation is that they perform care as given as per orders, as well as refusal via TAR, NJ Ex Order 26.4(b)(1) assessment and progress note. I would check TAR and progress note and if there's no documentation then care was not performed. If NJ Ex Order 26.4(b)(1) not done it could lead to NJ Ex Order 26.4(b)(or NJ Ex Order 26.4(b)(1) getting worse. If it's not documented, it's not done. Facility Policy was not followed if there are blanks, even if there's a progress note."

A review of the facility policy last revised June 2024 titled P & P Physician Order" policy revealed: "Treatment orders are transcribed and

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F 658	Continued From page 53 documented on the ETAR". A review of the facility policy last revised 10/2024 titled " Medication Administration Policy and Protocol" revealed, "The medication nurse must document any medication not given and the reason why, and if refused by the resident must notify the physician as appropriate depending on the medication."	F 658		
F 689 SS=K	N.J.A.C:8:39-27.1(a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint #: NJ185458 Based on interviews, medical record reviews, and review of pertinent facility documentation on [redacted], it was determined that the facility failed to: A) ensure the residents' safety by failing to implement interventions to prevent [redacted] from entering the facility and [redacted] incidents from occurring while in the facility, B) conduct a thorough investigation into a resident's (Resident #6) [redacted], and C) notify [redacted] and the New Jersey Department of Health (NJDOH) of the residents' [redacted].	F 689	F689 *Free of Accident Hazards/Supervision/Devices ELEMENT ONE: CORRECTIVE ACTION: • The [redacted] received re-education by the corporate officer on job description and facilities policies on conducting a thorough investigation for [redacted] and [redacted] and the requirements to report these incidents to the DOH[redacted]/LTCO on [redacted].	6/9/25

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F 689	Continued From page 54 1. On 2/21/25 at approximately 6:30 PM, the U.S. FOIA (b)(6) observed Resident #6 NJ Exec Order 26.4b1. Resident #6's NJ Exec Order 26.4b1, and he/she had U.S. FOIA (b)(6) The U.S. FO stated she administered NJ Exec Order 26 to the resident. Approximately NJ Exec Order 26.4b1, the resident NJ Exec Order 26.4b1 and was sent to the hospital. On NJ Exec Order 26.4, Resident #6 returned to the facility from the hospital with a diagnosis of an NJ Exec Order 26.4b1 2. On 4/1/25, Resident #6 was found sitting in his/her wheelchair NJ Exec Order 26.4b1. NJ Exec Order 26.4, and he/she NJ Exec Order 26.4b1. The doctor was notified, and the resident was sent to the hospital NJ Ex Order 26.4. Resident #6 returned to the facility from the hospital with a diagnosis of NJ Exec Order 26.4b1. 3. On 5/6/25, Resident #6 was NJ Exec Order 26.4b1 in his/her wheelchair NJ Exec Order 26.4b1. The resident was noted to have NJ Exec Order 26.4b1 The doctor was notified, and the resident was sent to the hospital. The U.S. FOIA (b)(6) stated that the NJ Exec Order 26.4b1 Resident #6 NJ Exec Order 26. According to the hospital Emergency Room (ER) documentation dated NJ Exec Order 2, the resident's diagnosis for the visit was NJ Exec Order 26.4b1 The facility had knowledge that Resident #6 had a history of NJ Exec Order 26.4b1 and failed to implement interventions that ensured the residents safety and NJ Exec Order 26.4b1 from entering the facility. This resulted in Resident #6 having NJ Exec Order 26.4b1 while in the facility and being sent to the hospital for NJ Exec Order 26.4b1	F 689	• All nursing staff was re-educated on the illicit drug use policy which includes reporting overdoses to the New Jersey Department of Health and police on 5/9/25. • The Director of Nursing re-investigated the incidents involving Resident #6 on NJ Ex Order 26.4(b) • An audit was conducted to identify all residents with a history of NJ Ex Order 26.4(b)(1) and/or NJ Ex Order 26.4(b)(1) on NJ Ex Order 26. • The Social Worker met with all residents with history of NJ Ex Order 26.4(b)(1) and/or NJ Ex Order 26.4(b)(1) to educate residents on the medical risks of NJ Ex Order 26.4(b)(1) use and NJ Ex Order 2 involvement. All residents were notified that upon return from out on pass they will be subjected to a search by nursing and/or security. Upon any suspicion of NJ Ex Order 26.4(b)(1), a room search will be conducted by nursing/security. All residents suspicious of NJ Ex Order 26.4(b)(1), will be required to open any incoming packages/deliveries in the presence of a staff member of nursing or security. If resident is found to be in possession of NJ Ex Order 26.4(b)(1) and/or if an NJ Ex Order 26.4(b)(1) occurs the resident will be subject to a possible 30-day discharge notice from the facility, and/or revoking of facility out on pass privileges on 5/9/25. • The Social Worker provided education to all residents with history of NJ Ex Order 26.4(b)(1) use and/ or NJ Ex Order 26.4(b)(1) on the availability of NJ Ex Order 26.4(b)(1) programs on 5/9/25. • The Social Worker met with Resident #6 to educate the resident on the availability of NJ Ex Order 26.4(b)(1) programs,	

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	315324	A. BUILDING _____ B. WING _____	C 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRENTON GARDENS REHABILITATION AND NURSING CENTER	512 UNION STREET TRENTON, NJ 08611

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F 689	Continued From page 55 NJ Exec Order 26.4b1. The facility failed to report Resident #6's [redacted] that occurred while in the facility to the NJDOH and the NJ Ex Order 26.4(b)(1). The facility's failure to protect Resident #6 from NJ Exec Order 26.4b1 placed all residents with a history of NJ Exec Order 26.4b1 in an Immediate Jeopardy (IJ) situation. The IJ began on 8/24/24, was identified on 5/8/25 at 6:00 PM, and was reported to the U.S. FOIA (b)(6) [redacted]. The U.S. FOIA (b)(6) was presented with the IJ template at that time. An acceptable removal plan was electronically mailed to the surveyor on 5/13/25 at 4:23 PM, indicating the facility's actions to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice. The U.S. FOIA (b)(6) [redacted]) provided education to all residents with a history of NJ Exec Order 26.4b1 on the medical risks with NJ Ex Order 26.4(b)(1), NJ Ex Order 26 involvement, possible discharge from the facility, and revoking of facility leave privileges. Education was provided to the residents on NJ Ex Order 26.4(b)(1) programs and NJ Ex Order 26.4(b)(1) consultations. Signage was placed at the entrance of the facility stating that NJ Ex Order 26.4(b)(1) were not allowed in the facility. Facility staff were educated that any NJ Ex Orde [redacted] is to be reported to the appropriate regulatory agencies immediately. The facility staff were educated on the new interventions implemented to help prevent NJ Ex Order 26.4(b)(1). These new interventions included education to the residents on the risks of a NJ Ex Order 26.4(b)(1), room searches, NJ Ex Order 26 involvement, possible discharge from the facility and revoking of facility leave privileges. The U.S. FOIA (b)(6)	F 689	the medical risks of NJ Ex Order 26.4(b)(1), p NJ Ex Orde involvement, possible 30-day discharge notice from the facility, and revoking of facility out on pass privileges on 5/9/25. • All nursing staff were re-educated on signs of overdose and policies to follow in cases of suspected overdose and availability of drug cessation programs for residents on 5/9/25. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: • All residents have the potential to be affected by this practice. ELEMENT THREE: SYSTEMIC CHANGES: • Policy signage was posted at the entrance stating that drugs and alcohol are not allowed in the home on 5/9/25. • All residents are educated about illicit drug use policy at Resident Council meetings. • The Social Worker meets with new residents who have history of illicit drug use / overdose to discuss policy and options for treatment of addiction. • Violations of illicit drug abuse policy are discussed at weekday clinical meetings and reported to the Licensed Nursing Home Administrator and Director of Nursing for follow up. ELEMENT FOUR: QUALITY ASSURANCE: • Root cause analysis was conducted	

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F 689	Continued From page 56 implemented an audit process that occurred during the morning daily clinical meeting that will identify the residents with a new history of [redacted] that occur in the facility and that the [redacted] were called, and the appropriate regulatory agencies were notified. The surveyor verified the removal plan on site on 5/15/25 and determined the IJ for F689 was removed as of 5/15/25. After the IJ removal plan, the non-compliance continued from 5/15/25 for no actual harm with the potential for more than minimal harm that is not an immediate jeopardy. The deficient practice was evidenced by the following: According to the AR, Resident #6 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted] r. According to the Quarterly MDS, an assessment tool dated [redacted], Resident #6 had a BIMS score of [redacted], which indicated the resident's NJ Exec Order 26.4b1. A review of Resident #6's PN dated 2/21/25 completed by the [redacted] revealed the [redacted] was called into the resident's room at [redacted] by staff. The resident was [redacted] in his/her wheelchair with NJ Exec Order 26.4b1. The resident's NJ Exec Order 26.4b1 [redacted]. A [redacted] was not effective (NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 was administered at NJ Exec Order 26.4b1 [redacted]. The resident was transferred to the hospital.	F 689	and a QAPI performance improvement project team formed to address clinical concerns. • Violations of illicit drug abuse policy are discussed at weekday clinical meetings. • Drug overdoses in the home are reported to the Licensed Nursing Home Administrator and Director of Nursing to ensure that the police were called and the New Jersey Department of Health was notified. • The Director of Nursing will report on audits of the weekday clinical meetings and any actions taken at the monthly Quality Assurance and Process Improvement Committee meeting committee x 3 months. Based on the results of these audits, a decision will be made regarding review and further direction as appropriate. DATE OF COMPLIANCE : June 9, 2025	

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A review of Resident #6's Emergency Department Documentation (EDD) with a visit date of [redacted] revealed under "Diagnosis from Today's Visit," [redacted]."

A review of the PN dated [redacted] completed by the [redacted]) revealed that Resident #6 was found sitting in his/her wheelchair and [redacted]. [redacted] and he/she [redacted]. The doctor was notified, and the resident was sent out [redacted]. The resident returned from the hospital and was [redacted].

A review of Resident #6's EDD with a visit date of [redacted] revealed under "Diagnosis from Today's Visit," [redacted]."

A review of the PN dated [redacted] completed by the [redacted] revealed that during rounds Resident #6 was noted to be [redacted] in his/her wheelchair. [redacted] was noted to the resident's [redacted]. The doctor was notified, and a new order given to send to hospital for [redacted] was called and the resident was sent to the Emergency Room (ER).

A review of Resident #6's EDD with a visit date of [redacted] revealed under "Diagnosis from Today's Visit," [redacted]."

A review of Resident #6's CP revealed a "Focus" revised on [redacted], that "Resident #6 had a history of [redacted]. Admitted to using [redacted] visit to deal with [redacted]. [redacted] Resident #6 had an incident here where

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he/she was NJ Exec Order 26.4b1 [redacted]

On 5/8/25 at 9:24 AM, the surveyors interviewed Resident #7 who stated he/she was the facility's NJ Ex Order 26.4(b)(1) . Resident #7 stated that he/she had seen the nurses, and the NJ Exec Order 26.4b1 to Resident #6 who had NJ Exec Order 26.4b1 [redacted]

On 5/8/25 at 10:33 AM, the surveyors interviewed the U.S. FOIA (b)(6) who stated, "Yes, he/she went to the hospital because he/she NJ Exec Order 26.4b1 ." The U.S. FOIA (b)(6) stated she was unaware if the resident had NJ Exec Order 26.4b1 . The U.S. FOIA (b)(6) further stated Resident #6 went to the NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 . The U.S. FOIA (b)(6) stated "Yes, he/she signs himself/herself out on pass. He/she is NJ Ex Ord and NJ Ex Order 26.4(b) and is his/her own responsible party."

On 5/8/25 at 11:55 AM, the surveyors interviewed Resident #6 who stated that he/she was at the [redacted] on NJ Exec Order 2 , when the staff reported that he/she was NJ Exec Order 26.4b1 . The resident stated that he/she NJ Exec Order 26.4b1 . Resident #6 further stated 'NJ Exec Order 26.4b1 [redacted] " Resident #6 stated 'NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 [redacted] " Resident #6 further stated 'NJ Exec Order 26.4b1 [redacted] " Resident #6 indicated that he/she had NJ Exec Order 26.4b1 in the facility before. The resident stated "Last time, it was a couple months. I didn't take anything, but they said I did and NJ Exec Order 26.4b1 ."

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F 689	Continued From page 59 On 5/8/25 at 1:21 PM, the surveyors interviewed the U.S. FO who stated Resident #6 was NJ Exec Order 26.4b1 of his/her room on NJ Exec Order 2. The U.S. F stated she immediately called NJ Ex Ord The U.S. F indicated "I am not sure if he/she NJ Exec Order 26.4b1." The U.S. F stated that on NJ Exec Order 26.4 she NJ Exec Order 26.4b1 to Resident #6. The U.S. FO further stated the resident's NJ Exec Order 26.4b1 The resident wasn't NJ Exec Order 26.4b1, but he/she was NJ Exec Order 26.4b1 Resident #6 NJ Exec Order 26.4b1." I had my stopwatch on and NJ Exec Order 26.4b1 NJ Exec Order 26.4b1." The U.S. F stated she completed an incident report for the NJ Exec Order 26.4b1 that occurred on NJ Exec Order 26.4. The U.S. F further indicated that she did not complete an incident report for the NJ Exec Order 26.4b1 that occurred on NJ Exec Order 2 because she wasn't sure if Resident #6 had NJ Exec Order 26.4b1 at that time. On 5/8/25 at 1:44 PM, the surveyors interviewed the U.S. FOIA (b) in the presence of the U.S. FOIA (b)(6). The U.S. FOIA (b) stated that Resident #6 went to the hospital on NJ Exec Order 2 because the resident had NJ Exec Order 26.4b1 . The U.S. FOIA (b) further stated she would have to review Resident #6's medical record to find out further information. The U.S. FOIA (b) stated, "Any resident with a BIMs score NJ Exec or above can go out of the facility NJ Exec Order 26.4b1 " She further stated, "This was made clear to me by the U.S. FOIA (b) (6) The U.S. FOIA (b) stated that the facility worked with Resident #6 to get him/her to go to the U.S. FOIA (b)(6) and that the resident agreed to go within the last week. On 5/8/25 at 1:44 PM, the surveyors interviewed the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b). The U.S. FOIA (b)(6) stated "I can't say for a fact that the residents are	F 689		

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bringing in [redacted] We can't search them." The [redacted] further stated "We understand we are in a [redacted] neighborhood. We are doing the best we can to NJ Exec Order 26.4b1 , but we can't infringe on the resident's rights."

On 5/8/25 at 2:35 PM, the surveyors conducted a follow-up interview with the [redacted] who reviewed Resident #6's PNs in the presence of the surveyors. The [redacted] stated she did not investigate Resident #6's NJ Exec Order 26.4b1 that occurred at the facility. The [redacted] stated that she thought that NJ Exec Order 26.4b1 that occurred on [redacted] was from the resident's [redacted] and that was why an investigation was not conducted. The [redacted] indicated that at that time, the facility changed the resident's plan of care by NJ Exec Order 26.4b1 medications. The [redacted] stated that after the [redacted] that occurred in [redacted], she had a discussion with the resident about his/her actions. The [redacted] indicated "No, I did not do an investigation. He/she was allowed outside and was not forthcoming about [redacted]." The [redacted] stated "I have not reported U.S. FOIA (b)(6) to the DOH because I have not seen that in the regulations. "The [redacted] further indicated "I would call [redacted] if I suspected someone was [redacted] The [redacted] stated that she was made aware by staff but could not remember who Resident #6 visited at the NJ Exec Order 26.4b1 [redacted] recently and were suspicious that the resident was NJ Exec Order 26.4b1. The [redacted] further stated, "I have not investigated this matter so far because I didn't have proof it happened."

A review of the facility's policy titled "Illegal Drug Use" dated 6/2024 revealed "The facility recognizes that we have an increase in admission

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F 689	Continued From page 61 of residents with a history or recent active drug use. If drug use is suspected, resident assessment and follow up treatment, if warranted is provided." A review of the facility's policy titled "Policy and Protocol for Incident Reporting" with a revised date of 9/2024 revealed "The Administrator and/or Director of Nursing will process all Reportable Events to the advocacy agencies required by state and federal regulations."	F 689		
F 835 SS=L	NJAC 8:39-27.1 (a) Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint #: NJ185458 Based on interviews, medical record reviews, and review of other pertinent facility documentation on 5/8/25, it was determined that the facility's [U.S. FOIA (b)(6)] and the administrative staff failed to ensure resident safety and well-being by failing to A) prevent [NJ Exec Order 26.4b1] from entering the facility and [NJ Ex Order 26.4(b)(1)] incidents from occurring, B) ensure a thorough investigation was completed for a staff to resident [NJ Exec Order 26.4b1] involving Resident #3 and [NJ Exec Order 26.4b1] [redacted] that occurred in the facility involving	F 835	F835 Administration ELEMENT ONE: CORRECTIVE ACTION: • The abuse and illicit drug policies were reviewed and updated. • The [U.S. FOIA (b) (6)] [redacted] and [U.S. FOIA (b) (6)] received re-education by the corporate officer on job description and abuse and illicit drug policies which includes reporting to the New Jersey Department of Health and police on 5/9/25. • The Licensed Nursing Home Administrator and Director of Nursing	6/9/25

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F 835	Continued From page 62 Resident #6, and C) ensure that the police and the New Jersey Department of Health (NJDOH) were notified of any U.S. FOIA (b)(6) that occurred in the facility. The facility's administrative staff failed to develop safety measures to ensure NJ Exec Order 26.4b1 were not used by its residents and ensure that thorough investigations were completed for a staff to resident NJ Exec Order 26.4b1 allegation and NJ Exec Order 26.4 that occurred, which placed all facility residents in an Immediate Jeopardy (IJ) situation. The IJ began on NJ Ex Order 26.4(and was identified on 5/8/25 at 6:00 PM and was reported to the U.S. FOIA (b)(. The U.S. FOIA (b)(was presented with the IJ template at that time. An acceptable removal plan was electronically mailed to the surveyor on 5/13/25 at 4:23 PM, indicating the facility's actions to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice. The Corporate Officer re-educated the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) on their job descriptions and the facility's policies on conducting a thorough investigation and the facility's elimination efforts on NJ Exec Order 26.4b1 at the facility. Signage was posted in the front of the building that no alcohol or drugs were allowed in the facility. The U.S. FOIA (b)(or designee educated all the facility staff on elimination of NJ Exec O use in the facility and to report any NJ Exec Order 26.4b1 use to the DOH and NJ Ex Order 26.4(b)(1) . The U.S. FOIA (b)(and the U.S. FOIA (b)(audited all incidents and accidents from NJ Ex Order 26.4(b)(1) to ensure there were no additional unresolved NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b and NJ Exec Order 26.4b1 use identified. The U.S. FOIA (b)(6) implemented an audit process that occurred during the morning daily clinical meeting to	F 835	re-educated staff on abuse and illicit drug policies which includes reporting to the New Jersey Department of Health and police on 5/9/25. • The Social Worker met with residents with history of NJ Ex Order 26.4(b)(1) and/or NJ Ex Order 26.4(b)(1) to educate on the availability of NJ Ex Order 26.4(b)(1) programs, the medical risks of NJ Ex Order 26.4(b)(1) , NJ Ex Order 2 involvement, possible discharge from the facility, and revoking of facility leave privileges on 5/9/25. • Nursing staff was re-educated on signs of NJ Ex Order 26.4(b)(1) and policies to follow in cases of suspected NJ Ex Order 26.4(b)(1) and availability of NJ Ex Order 26.4(b)(1) programs for residents on 5/9/25. • The Director of Nursing / designee re-educated staff on signs of NJ Ex Order 26.4(b)(1) and policies to follow in cases of NJ Exec Order 26.4b1 • The Director of Nursing re-investigated the incidents involving Residents #3, #6, #8, and #15. • Care plans of residents cited in the 2567 were reviewed and/ or updated by the interdisciplinary team. • Incidents and accidents occurring from January through May were audited to ensure there were no identified, unresolved NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(or NJ Ex Order 26.4(b)(1) . ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: • All residents have the potential to be affected by this practice.	

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TRENTON GARDENS REHABILITATION AND NURSING CENTER	**512 UNION STREET TRENTON, NJ 08611**

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F 835	Continued From page 63 assess NJ Ex Order 26.4(b)(1) and any NJ Ex Order 26.4(b)(1 activity and ensure these concerns were addressed per the facility policy. The surveyor verified the removal plan on site on 5/15/25 and determined the IJ for F835 was removed as of 5/15/25. After the IJ removal plan, the non-compliance continued from 5/15/25 for no actual harm with the potential for more than minimal harm that is not an immediate jeopardy. The deficient practice was evidenced by the following: A review of the facility's undated job description titled "Administrator" revealed under "Purpose of Your Job Description," "The primary purpose of your position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standard guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times." Under "Administrative Functions," "Assist department directors in the development, use, and implementation of departmental policies and procedures and professional standards of practice." A review of the facility's undated job description titled "Director of Nursing" revealed under "Essential Duties and Responsibilities," "Direct, develop, implement, review and revise nursing service goals and objectives. Establish and maintain standards of quality nursing practice. Maintain and enforce department and facility procedures and safety standards aimed at	F 835	ELEMENT THREE: SYSTEMIC CHANGES: • Policy signage was posted at the entrance stating that NJ Ex Order 2 and NJ Ex Order 26.4 are not allowed in the home on 5/9/25. • The Social Worker meets with new residents who have history of NJ Ex Order 26.4(b)(1) and/or NJ Ex Order 26.4(b)(1) to discuss policy and options for treatment of NJ Ex Order 26.4(b)(1) • NJ Ex Order 26.4(b)(1) and violations of NJ Ex Order 26.4(b)(1) policy are discussed at weekday clinical meetings and reported to the Licensed Nursing Home Administrator and Director of Nursing for follow up. ELEMENT FOUR: QUALITY ASSURANCE: • Root cause analysis was conducted and a QAPI performance improvement project team formed to address clinical concerns. • Abuse allegations and violations of illicit drug abuse policy are discussed at weekday clinical meetings and all concerns reported to the Licensed Nursing Home Administrator and Director of Nursing for follow up. • The Director of Nursing will report on audits of the daily meeting and any actions taken at the monthly Quality Assurance and Process Improvement Committee meeting committee x 3 months. Based on the results of these audits, a decision will be made regarding review and further direction as appropriate. DATE OF COMPLIANCE : June 9, 2025	

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 _____	C 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 835	Continued From page 64 accident prevention..." 1. According to the AR, Resident #6 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted] According to the Quarterly MDS, an assessment tool dated [redacted], Resident #6 had a BIMS score of [redacted] which indicated the resident's NJ Exec Order 26.4b1 A review of Resident #6's PN dated [redacted] completed by the [redacted] revealed the [redacted] was called into the resident's room at [redacted] by staff. The resident was [redacted] in his/her wheelchair with loud breathing. The resident's NJ Exec Order 26.4b1 [redacted]). NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 [redacted]. The resident was transferred to the hospital. A review of Resident #6's Emergency Department Documentation (EDD) with a visit date of [redacted] revealed under "Diagnosis from Today's Visit," NJ Exec Order 26.4b1 [redacted]." A review of the PN dated [redacted] completed by the U.S. FOIA (b)(6) [redacted]) revealed that Resident #6 was found sitting in his/her wheelchair and NJ Exec Order 26.4b1 [redacted] the resident, and he/she NJ Exec Order 26.4b1 [redacted]. The doctor was notified, and the resident was sent out [redacted]. The resident returned from the hospital and was NJ Exec Order 26.4b1 [redacted].	F 835		

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F 835	Continued From page 65	F 835		

A review of Resident #6's Emergency Department Documentation (EDD) with a visit date of [redacted] revealed under "Diagnosis from Today's Visit," [redacted]."

A review of the PN dated [redacted] completed by the [redacted] revealed that during rounds Resident #6 was noted to be [redacted] his/her wheelchair. [redacted] was noted to the resident's [redacted]. The doctor was notified, and a new order given to send to hospital for change in [redacted]. [redacted] was called and the resident was sent to the Emergency Room (ER).

A review of Resident #6's EDD with a visit date of [redacted] revealed under "Diagnosis from Today's Visit," '[redacted]."

A review of Resident #6's CP revealed a "Focus" revised on [redacted], that "Resident #6 had a history of [redacted] use. Admitted to using [redacted] visit to deal with [redacted] Resident #6 had an incident here where he/she was [redacted] due to [redacted] possibly due to [redacted]"

On 5/8/25 at 1:44 PM, the surveyors interviewed the [redacted] in the presence of the [redacted]. The [redacted] stated "I can't say for a fact that the residents are [redacted]. We can't search them." The [redacted] further stated "We understand we are in a [redacted] neighborhood. We are doing the best we can to prevent the [redacted], but we can't infringe on the resident's rights."

On 5/8/25 at 2:35 PM, the surveyors interviewed the [redacted] who stated she did not investigate

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F 835	Continued From page 66	F 835		

Resident #6's NJ Exec Order 26.4b1 that occurred at the facility. The U.S. FOIA (b) stated that she thought that the NJ Exec Order 26.4b1 that occurred on U.S. FOIA (b)(6) was from the resident's prescribed medication and that was why an investigation was not conducted. The U.S. FOIA (b) indicated that at that time, the facility changed the resident's plan of care by NJ Exec Order 26.4b1 U.S. FOIA (b)(6) medications. The U.S. FOIA (b) stated that after the NJ Exec Ord that occurred in NJ Exec Order 26.4b1 she had a discussion with the resident about his/her actions. The U.S. FOIA (b) indicated "No, I did not do an investigation. He/she was NJ Ex Order 26.4(b)(1) and was not forthcoming about NJ Exec Order 26.4b1." The U.S. FOIA (b) stated "I have not reported NJ Exec Order 26.4b1 to the DOH because I have not seen that in the regulations. The U.S. FOIA (b) confirmed she did not notify NJ Ex Order 26.4(b)(1) regarding Resident #6's NJ Exec Order 26.4 that occurred in the facility. The U.S. FOIA (b) stated that she was made aware by staff but could not remember who Resident #6 visited at the end of the facility's property recently and were suspicious that the resident was NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) further stated, "I have not investigated this matter so far because I didn't have proof it happened."

According to the Admission Record (AR), Resident #2 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1

According to the Quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b Resident #2 had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1, which indicated the resident's NJ Exec Order 26.4b1.

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F 835	Continued From page 67	F 835		

According to the AR, Resident #3 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted]

According to the Quarterly MDS, and assessment tool dated [redacted], Resident #3 had a BIMS score of [redacted] which indicated the assessment could not be completed. The MDS further revealed the resident was NJ Exec Order 26.4b1 [redacted]

On 5/7/25 at 10:17 AM, the surveyor interviewed Resident #2, who stated he/she went into the hallway at 3:00 AM and observed the medication cart in front of Resident #3's room. Resident #2 could not provide the surveyor with the exact date the NJ Ex Order 26.4(b)(1) occurred. Resident #2 stated he/she waited about half an hour for LPN #1 to come out Resident #3's room. Resident #2 then went back to his/her room for a brief period and then returned to the hallway. Resident #2 stated he/she still observed the medication cart in front of Resident #3's room. Resident #2 stated he pushed the medication cart and went into Resident #3's room and observed LPN #1 [redacted] and [redacted] Resident #3's [redacted] while NJ Ex Order 26.4(b)(1). Resident #2 stated he observed Resident #3 with [redacted] Resident #2 further indicated he/she asked LPN #1 what she was doing. The resident stated that the LPN told him/her that she was giving medical attention to Resident #3. Resident #2 indicated he/she reported the alleged incident the next day to the U.S. FOIA (b) (6) and the supervisor but was unsure of the supervisor's name.

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F 835	Continued From page 68 On 5/7/25 at 2:30 PM, the surveyor interviewed the [U.S. FOIA (b)] who indicated she conducted a [NJ Ex Order 26.4(b)] assessment on Resident #3 and interviewed Resident #2, LPN #1, the [U.S. FOIA (b)(6)]. The [U.S. FOIA (b)] stated "No, I did not speak to any residents she (LPN #1) cared for. No, I did not speak to any other staff members. I felt the people I spoke with gave me an honest report." The [U.S. FOIA (b)] indicated that in the past she had collected resident and staff statements but denied collecting them for this incident. The [U.S. FOIA (b)] further stated "If I feel it is warranted, I would interview the residents. I did not feel it was warranted because I did not have a time frame of when the incident happened." On 5/8/25 at 4:29 PM, the surveyor interviewed the [U.S. FOIA (b)(6)] who stated that a thorough investigation should be conducted for all [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b)(6)] further indicated "All residents on a staff member's assignment for an abuse allegation should be interviewed." The [U.S. FOIA (b)(6)] stated that the staff should have been interviewed as well. The [U.S. FOIA (b)(6)] acknowledged that the facility's policy was not followed regarding conducting a thorough investigation. NJAC 8:39-9.2 (a)	F 835		

New Jersey Department of Health

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	061113	A. BUILDING: _____ B. WING _____	C 05/15/2025

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TRENTON GARDENS REHABILITATION AND N	512 UNION STREET TRENTON, NJ 08611

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ175920, NJ176848, NJ179424, NJ181381, NJ182907, NJ183647, NJ184225, NJ184250, NJ184351, NJ185458, NJ186028 Based on interviews and review of facility documents on 05/15/2025, it was determined that the facility failed to ensure staffing ratios were met for 12 of 14-day shifts and 1 of 14 evening shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health	S 560	S560 Mandatory access to care ELEMENT 1 • The Staffing Coordinator was re-educated on New Jersey minimum staffing requirements for nursing homes. ELEMENT 2 • All residents have the potential to be affected by this practice. ELEMENT 3	6/9/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 06/09/25

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S 560	Continued From page 1 (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 as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (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 of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One 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. For the 2 weeks of staffing prior to complaint survey from 04/20/2025 to 05/03/2025, the facility was deficient in CNA staffing for residents on 12 of 14-day shifts, and deficient in total staff for residents on 1 of 14 evening shifts as follows: On 04/20/25 the facility had 17 CNAs for 176 residents on the day shift, required at least 22 CNAs. On 04/20/25 the facility had 12 total staff for 176 residents on the overnight shift, required at least 13 total staff. On 04/21/25 the facility had 20 CNAs for 176 residents on the day shift, required at least 22 CNAs.	S 560	• The Staffing Coordinator will report staffing weekly to the Administrator / Director of Nursing / designee. • Flyers are hung in staff areas advertising open staff positions. • Indeed is used to advertise for open staff positions. • Agencies are used to fill open staff positions. ELEMENT 4 • Root cause analysis was conducted and a QAPI performance improvement project team formed to address staffing concerns. • Staffing is discussed at weekday clinical meetings and concerns reported to the Licensed Nursing Home Administrator and Director of Nursing for follow up. • The Director of Nursing will report on staffing audits and any actions taken at the monthly Quality Assurance and Process Improvement Committee meetings x 3 months. Based on findings, a decision will be made regarding review and further directives. Date of Completion: June 9, 2025	

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S 560	Continued From page 2 On 04/23/25 the facility had 18 CNAs for 173 residents on the day shift, required at least 22 CNAs. On 04/24/25 the facility had 20 CNAs for 172 residents on the day shift, required at least 21 CNAs. On 04/25/25 the facility had 19 CNAs for 171 residents on the day shift, required at least 21 CNAs. On 04/26/25 the facility had 17 CNAs for 165 residents on the day shift, required at least 21 CNAs. On 04/27/25 the facility had 14 CNAs for 164 residents on the day shift, required at least 20 CNAs. On 04/28/25 the facility had 16 CNAs for 164 residents on the day shift, required at least 20 CNAs. On 04/30/25 the facility had 19 CNAs for 164 residents on the day shift, required at least 20 CNAs. On 05/01/25 the facility had 16 CNAs for 169 residents on the day shift, required at least 21 CNAs. On 05/02/25 the facility had 20 CNAs for 166 residents on the day shift, required at least 21 CNAs. On 05/03/25 the facility had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs.	S 560		

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S1680	Continued From page 3	S1680		
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic	S1680		6/9/25

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S1680	Continued From page 4 care 1.50 hours/day This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ175920, NJ176848, NJ179424, NJ181381, NJ182907, NJ183647, NJ184225, NJ184250, NJ184351, NJ185458, NJ186028 Based on review of the Nurse Staffing Reports for the weeks of 04/20/2025 to 05/03/2025 it was determined that the facility failed to provide at least minimum staffing levels for 2 of 14 days. The required staffing hours and actual staffing hours are as follows:	S1680	S1680 Mandatory nurse staffing ELEMENT 1 • The Staffing Coordinator was re-educated on New Jersey minimum staffing requirements for nursing homes. ELEMENT 2 • All residents have the potential to be affected by this practice.	

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S1680	Continued From page 5 For the week of 04/27/25 Required Staffing Hours: 459.25 On 04/27/25 the facility had 416 actual staffing hours, for a difference of -43.25 hours. On 05/03/25 the facility had 440 actual staffing hours, for a difference of -19.25 hours.	S1680	ELEMENT 3 • The Staffing Coordinator will report staffing daily to the Administrator / Director of Nursing / designee. • Flyers are hung in staff areas advertising open staff positions. • Indeed is used to advertise for open staff positions. • Agencies are used to fill open staff positions. ELEMENT 4 • Root cause analysis was conducted and a QAPI performance improvement project team formed to address staffing concerns. • Staffing is discussed at weekday clinical meetings and concerns reported to the Licensed Nursing Home Administrator and Director of Nursing for follow up. • The Director of Nursing will report on staffing audits and any actions taken at the monthly Quality Assurance and Process Improvement Committee meetings x 3 months. Based on findings, a decision will be made regarding review and further directives. Date of Completion: June 2025	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315324 Y1	A. Building B. Wing Y2	6/13/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TRENTON GARDENS REHABILITATION AND NURSING CENTER	512 UNION STREET TRENTON, NJ 08611

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0600	Correction	ID Prefix F0609	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.12(a)(1)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed
LSC	06/09/2025	LSC	06/09/2025	LSC	06/09/2025
ID Prefix F0610	Correction	ID Prefix F0627	Correction	ID Prefix F0657	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)(iv)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed
LSC	06/09/2025	LSC	06/09/2025	LSC	06/09/2025
ID Prefix F0658	Correction	ID Prefix F0689	Correction	ID Prefix F0835	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.70	Completed
LSC	06/09/2025	LSC	06/09/2025	LSC	06/09/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 5/15/2025

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061113 Y1	A. Building B. Wing Y2	6/13/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TRENTON GARDENS REHABILITATION AND NURSING CENTER	512 UNION STREET TRENTON, NJ 08611

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 06/09/2025	ID Prefix S1680 Reg. # 8:39-25.2(b)(1)&(2) LSC	Correction Completed 06/09/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 5/15/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			