

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315324	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/14/2025
NAME OF PROVIDER OR SUPPLIER TRENTON GARDENS REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 UNION STREET , TRENTON, New Jersey, 08611	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>INITIAL COMMENTS</p> <p>Complaint #: 2620207</p> <p>Survey Dates: 10/14/2025</p> <p>Census: 167</p> <p>Sample Size: 3</p> <p>A complaint survey was conducted at Trenton Gardens Rehabilitation and Nursing Center on 10/07/2025 through 10/14/2025, to determine compliance with 42 CFR Part 483 requirements for Long-Term Care Facilities.</p> <p>During the survey, a finding which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR 483.25(d)(2) F 689, as the facility failed to ensure a resident (Resident #2) whose NJ Ex Order 26.4(b)(1) were NJ Ex Order 26.4(b)(1) did not have NJ Ex Order 26.4(b)(1) in their possession or NJ Ex Order 26.4(b)(1) in the facility in the presence of NJ Ex Order 26.4(b)(1) to prevent NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) from NJ Ex Order 26.4(b)(1). During an interview with the U.S. FOIA (b) (6) () on 10/07/2025, she stated that while conducting her rounds on NJ Ex Order 26.4(b)(1), at approximately 8:00 P.M., she observed Resident #2 seated in a wheelchair, NJ Ex Order 26.4(b)(1) in Resident #1 and Resident #3's room. The U.S. F stated that Resident #2 did not reside in that room; they were talking to Resident #3; and Resident #1, who was present, had NJ Ex Order 26.4(b)(1). The U.S. F stated that Resident #2 saw her entering the room and immediately tried to NJ Ex Order 26.4(b)(1) on the wheelchair, and she stated, "No, no, no. You're NJ Ex Order 26.4(b)(1) that in your NJ Ex Order 26.4(b)(1) and the resident handed it to her. The U.S. F stated that a search of Resident #2's wheelchair revealed NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). During an interview with the U.S. FOIA (b) (6) () on 10/07/2025, she stated that Resident #2 had already had NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) policy which included NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1).</p>	F0000		10/15/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0000	Continued from page 1 The facility's U.S. FOIA was notified of the F 689 IJ and was provided the IJ Template on 10/08/2025 at 4:24 P.M. An acceptable Removal Plan (RP) was received on 10/12/2025 at 5:52 P.M., indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice to include: the U.S. F immediately removed the NJ Ex Order 26.4 from Resident #2; Resident #2 was searched, and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) was confiscated and destroyed; and Resident #2 was placed on NJ Ex Order 26.4(b)(1) until their discharge from the facility on NJ Ex Order 26.4(b)(1). On NJ Ex Order 26.4(b)(1), the U.S. F educated Resident #2 and Resident #3 that NJ Ex Order 26.4 was prohibited in a resident room. On 10/08/2025, nurse leaders began educating all residents who NJ Ex Order 26.4 on the facility's NJ Ex Order 26.4 policy and the dangers of NJ Ex Order 26.4, and their rooms and equipment were searched by the U.S. FOIA (b) (6) for violation of the NJ Ex Order 26.4 policy. On 10/10/2025, the nurse leaders and U.S. FOIA (b) (6) re-educated all staff on the NJ Ex Order 26.4 policy and the dangers of NJ Ex Order 26.4(b)(1). The surveyor verified the implementation of the RP on-site on 10/14/2025, and determined that the immediacy for F 689 was removed as of 10/14/2025 at 2:23 P.M.	F0000		
F0689 SS = SQC-L	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 #2620207	F0689	The NJ Ex Order 26.4 was immediately removed from Resident #2 by the Nursing Supervisor. The Supervisor reformed resident #2 that it is NJ Ex Order 26.4(b)(1) the building and the dangers of NJ Ex Order 26.4(b)(1). Resident #2 belongings were NJ Ex Order 26.4 and any NJ Ex Order 26.4(b) items removed. Resident #2 was immediately placed on NJ Ex Order 26.4(b)(1) until NJ Ex discharge. All residents have the potential to be affected by this deficient practice. The DON/Designee reeducated all smoking residents about the smoking policy and the dangers of smoking near oxygen. The DPOC RN/Designee reeducated all staff about the smoking policy and the dangers of smoking near oxygen. The Adon/Designee conducted room and equipment searches for any smoking material in violation of the smoking policy/contract of all current smoking residents and those that had their privileges revoked. The ADON/Designee will continue to audit daily for 4 weeks 15 residents, a combination of current and	10/17/2025

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<p>F0689 SS = SQC-L</p>	<p>Continued from page 2 Based on interviews, medical record review, and review of other pertinent facility documentation on 10/07/2025, it was determined that the facility failed to ensure a resident (Resident #2) whose [redacted] were [redacted] did not have [redacted] in their possession or [redacted] the facility in the presence of [redacted] to prevent NJ Ex Order 26.4(b)(1) and [redacted] from NJ Ex Order 26.4(b)(1). This deficient practice was identified for 1 of 3 residents (Resident #2) reviewed for [redacted].</p> <p>During an interview with the U.S. FOIA (b) (6) [redacted] on 10/07/2025, she stated that while conducting her rounds on [redacted] at approximately 8:00 P.M., she observed Resident #2 seated in a wheelchair, NJ Ex Order 26.4(b)(1) in Resident #1 and Resident #3's room. The [redacted] stated that Resident #2 did not reside in that room; they were talking to Resident #3; and Resident #1, who was present, had [redacted]. The [redacted] stated that Resident #2 saw her entering the room and immediately tried to put out the [redacted] on the wheelchair, and she stated, "No, no, no. You're not supposed to have that [redacted]" and the resident handed it to her. The [redacted] stated that a search of Resident #2's wheelchair revealed [redacted] and [redacted]. During an interview with the U.S. FOIA (b) (6) [redacted] on 10/07/2025, she stated that Resident #2 had already had [redacted] for [redacted] of the [redacted] policy which included the [redacted] [redacted], and [redacted].</p> <p>The facility's failure to ensure a resident, whose [redacted] were [redacted] did not have [redacted] in their possession or [redacted] the facility in the presence of [redacted] placed all residents at risk for serious harm, injury, or death from accidental explosion or fire from [redacted]. This resulted in an Immediate Jeopardy (IJ) situation.</p> <p>The IJ began on 09/16/2025 at 8:00 P.M., after Resident #2 was observed [redacted] in Resident #1's room while [redacted] was [redacted]. The facility was notified of the IJ on 10/07/2025 at 4:24 P.M. The facility submitted an acceptable Removal Plan (RP) on 10/12/2025 at 5:52 P.M. The surveyor verified the implementation of the RP during the on-site survey on 10/14/2025.</p> <p>The evidence was as follows:</p>	<p>F0689</p>	<p>Continued from page 2 revoked smokers for any smoking material in violation of the facility policy and contract. Audits will continue 3x weekly for an additional 8 weeks of 15 residents, a combination of current and revoked smokers for any smoking material in violation of the facility policy and contract.</p> <p>The DON/Designee will review weekly the results of these audits. The outcomes will be brought by the DON/Designee to the monthly QAPI meeting for 3 months to determine the need of future audits.</p>	

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F0689 SS = SQC-L	<p>Continued from page 3</p> <p>A review of the facility's "Smoking Policy and Procedure" dated revised 05/2025, included that the purpose of the policy was, "To provide a safe environment for all..." The Procedure/Protocol section included, "... 3. Residents will only be allowed to smoke in the designated facility Smoking Area, 4. All tobacco products ... will be kept at the Reception Desk, 5. No tobacco products or lighting materials will be allowed to be kept on the Resident's person or stored in their rooms [...] 16. E-Cigarette and Vape smoking will not be permitted within the building..."</p> <p>A review of the Facility Reportable Event (FRE) sent to the New Jersey Department of Health (NJDOH), indicated that on 09/16/2025 at 8:00 P.M., while completing rounds, the U.S. FOIA observed Resident #2 in Resident #1's room while NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1) was immediately taken away and Resident #2 was NJ Ex Order 26.4(b)(1) of the room. The FRE indicated that Resident #2's, "... NJ Ex Order 26.4(b)(1) privileges were NJ Ex Order 26.4(b)(1) prior to this event for other NJ Ex Order 26.4(b)(1). The FRE also revealed that a NJ Ex Order 26.4(b)(1) Resident #2's room and wheelchair led to the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and the resident was then placed on NJ Ex Order 26.4(b)(1)</p> <p>Further review of the FRE documentation that was provided by the facility on 10/07/2025, included the following:</p> <ul style="list-style-type: none"> -Incident Summation Report. -Physical Assessment of Resident #2. -Incident Investigation Form. -Employee Statement from assigned nurse. -Statements from the U.S. FOIA who interviewed Resident #2 and the U.S. FOIA (b) (6). <p>No documentation was provided regarding statements collected or assessments completed for Resident #1 or Resident #3 on the night of the incident.</p> <p>1. On 10/07/2025 at 9:32 A.M., the surveyor observed Resident #1 lying in bed asleep. The surveyor was unable to interview the resident during the survey. A review of the resident's medical record was conducted.</p>	F0689		

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<p>F0689 SS = SQC-L</p>	<p>Continued from page 4 According to the Admission Record face sheet, an admission summary, Resident #1 was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1).</p> <p>A review of Resident #1's comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b)(1), revealed that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26.4(b)(1) out of 15, which indicated that the resident's cognition was NJ Ex Order 26.4(b)(1). A further review of the MDS revealed that the resident required NJ Ex Order 26.4(b)(1).</p> <p>A review of Resident #1's Order Summary Report (OSR) revealed an active order for NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) via NJ Ex Order 26.4(b)(1), that was initiated on NJ Ex Order 26.4(b)(1). A review of the resident's corresponding Medication Administration Record (MAR) for NJ Ex Order 26.4(b)(1), revealed that on the evening shift of NJ Ex Order 26.4(b)(1), the box was signed indicating that the resident had NJ Ex Order 26.4(b)(1) in place.</p> <p>A further review of the medical record did not include documentation of a statement or an assessment related to the incident.</p> <p>2. Resident #2 was not at the facility at the time of the survey. A closed medical record review was conducted.</p> <p>According to the Admission Record face sheet, Resident #2 was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1).</p> <p>A review of Resident #2's comprehensive MDS dated NJ Ex Order 26.4(b)(1), revealed that the resident had a BIMS score of NJ Ex Order 26.4(b)(1) out of 15, which indicated that the resident's cognition was NJ Ex Order 26.4(b)(1). A further review of the MDS revealed that the resident currently NJ Ex Order 26.4(b)(1).</p> <p>A review of Resident #2's care plan (CP) revealed that the resident had a focus related to NJ Ex Order 26.4(b)(1) that was initiated on NJ Ex Order 26.4(b)(1). The focus included:</p>	<p>F0689</p>		

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F0689 SS = SQC-L	<p>Continued from page 5</p> <p>-[Resident #2] is [redacted] with [redacted] policy. [They] [redacted] policy.</p> <p>-[Out on pass] changed to not permitted [redacted] facility.</p> <p>-[Resident #2] was observed [redacted] in room.</p> <p>The focus area included a revision date of [redacted] but did not indicate when each individual update was made to this goal.</p> <p>A further review of the resident's CP included interventions as follows:</p> <p>[redacted] [redacted] [redacted] were [redacted]. The resident was re-educated on the [redacted] policy and informed of the [redacted].</p> <p>[redacted]: The resident was re-educated on [redacted] and options were offered.</p> <p>[redacted]: [Out on pass] changed to [redacted] the facility.</p> <p>[redacted] [redacted] initiated.</p> <p>[redacted]: Continued education with use of [redacted].</p> <p>[redacted] [redacted] and [redacted] as well.</p> <p>[redacted]: Staff were to continue to perform random [redacted].</p> <p>A review of the Resident #2's Progress Notes (PN) from [redacted], revealed the following:</p> <p>[redacted] at 10:50 A.M., the Social Worker (SW #1): Team met with the resident to discuss the resident's [redacted] of the facility's [redacted] contract. The resident admitted to [redacted] and [redacted] was [redacted]. The resident acknowledged understanding of the [redacted].</p> <p>[redacted] at 11:43 A.M., the [redacted] Team discussed resident's [redacted] of [redacted] with doctor, [redacted] was ordered, and the CP was updated.</p>	F0689		

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<p>F0689 SS = SQC-L</p>	<p>Continued from page 6 [redacted] at 1:29 P.M., the [redacted] U.S. FOIA Met with resident to discuss the resident's understanding of the [redacted] NJ Ex Order 26.4(b)(1) [redacted] NJ Exec Order 26.4(b) [redacted] [redacted] at 5:32 P.M., SW #2: Team met with resident to discuss a [redacted] incident that occurred in the facility's day room." [redacted] at 12:44 P.M., Licensed Practical Nurse (LPN #1): "Resident is [redacted] [physician] made aware..." [redacted] 5:45 P.M., SW #2: Team met with the resident to discuss that the resident was observed "outside on the facility grounds [redacted] Due to the incident, the resident's [Out of Facility] passes were [redacted] and [redacted] were "suspended indefinitely" due to [redacted] of sharing [redacted] the facility, and bringing [redacted] on the unit. The resident continues with the [redacted] NJ Ex Order 26.4(b)(1) [redacted] -09/17/2025 at 6:09 P.M. SW #2: Team met with resident to discuss incident related to Resident #2 [redacted] in a room with [redacted] and [redacted] were called. The resident was informed that [redacted] would continue, and they could be subject to [redacted] NJ Exec Order 26.4b1 [redacted]. Their [redacted] continues to be [redacted] NJ Exec Order 26.4b1 [redacted] A review of Resident #2's medical record indicated that the resident was connected to a [redacted] provider prior to the incident, but there was no indication that the resident was seen after the incident occurred. A further review of the medical record revealed that Resident #2's most recent [redacted] Assessment, dated [redacted] indicated that the resident did not understand the facility's [redacted] policy. 3. On 10/07/2025 at 9:34 A.M., Resident #3 was observed lying in bed awake. When asked about the incident, the resident reported hearing about a resident [redacted] the room but denied being in the room at the time of the incident. The resident further stated being educated about [redacted] around the [redacted] was very dangerous and that no [redacted] were to be kept in the room. According to the Admission Record face sheet, Resident #3 was admitted to the facility with diagnoses that</p>	<p>F0689</p>		

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F0689 SS = SQC-L	<p>Continued from page 8</p> <p>#2's NJ Ex Order 26.4(b)(1) had previously been NJ Ex Order 26.4(b)(1) due to the resident's NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) policy including: the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) on the property outside of the NJ Ex Order 26.4(b)(1), and vaping on the unit. The U.S. FOIA stated that she was contacted on the night of NJ Ex Order 26.4(b)(1) 5, by the U.S. FOIA who informed her that Resident #2 was NJ Ex Order 26.4(b)(1) in another resident's room in the presence of NJ Ex Order 26.4(b)(1). The U.S. FOIA stated could not recall the exact time, and that the U.S. FOIA said she immediately removed the NJ Ex Order 26.4(b)(1). The U.S. FOIA instructed the U.S. FOIA to place Resident #2 on NJ Ex Order 26.4(b)(1) and that a search of Resident #2's wheelchair was immediately done, and a NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) were NJ Ex Order 26.4(b)(1) and disposed of. The U.S. FOIA further stated that neither of these were allowed on the unit, and the resident should not have been NJ Ex Order 26.4(b)(1). The U.S. FOIA stated that none of the resident's prior incidents involved NJ Ex Order 26.4(b)(1) in a room NJ Ex Order 26.4(b)(1).</p> <p>During a telephone interview with LPN #1, the surveyor asked her about a PN dated NJ Ex Order 26.4(b)(1) at 12:44 P.M. LPN #1 stated that she observed Resident #2 with a NJ Ex Order 26.4(b)(1) while in a hallway on the unit, and she saw NJ Ex Order 26.4(b)(1) and then the resident placed it in their pocket. LPN #1 stated that she immediately reported it to the doctor who discontinued the resident's NJ Ex Order 26.4(b)(1). LPN #1 further stated that residents were not allowed to have NJ Ex Order 26.4(b)(1) or any NJ Ex Order 26.4(b)(1) on the unit; they were to be kept at the front desk. When asked if she addressed the resident and/or reported the incident to anyone, she stated no and that, "The resident was NJ Ex Order 26.4(b)(1)."</p> <p>During an interview with the U.S. FOIA on 10/07/2025 at 3:06 P.M., she stated that while conducting her rounds on NJ Ex Order 26.4(b)(1), at approximately 8:00 PM, she observed Resident #2 seated in a wheelchair NJ Ex Order 26.4(b)(1) in Resident #1's room, while Resident #1's NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1). The U.S. FOIA stated that Resident #2 did not reside in that room, but that she observed Resident #2 speaking with Resident #3 who also resided in that room. The U.S. FOIA stated that Resident #2 saw her entering the room and immediately tried to NJ Ex Order 26.4(b)(1) on the wheelchair, and she stated, "No, no, no. You're NJ Ex Order 26.4(b)(1) in your possession," and the resident handed it to her. The U.S. FOIA stated that Resident #1 slept throughout the entire incident, and she observed that NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1). The U.S. FOIA stated that she then explained to Resident #2 that a NJ Ex Order 26.4(b)(1) would have to be conducted, and the resident</p>	F0689		
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NAME OF PROVIDER OR SUPPLIER TRENTON GARDENS REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 UNION STREET , TRENTON, New Jersey, 08611	
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F0689 SS = SQC-L	<p>Continued from page 9</p> <p>responded, "Yeah, yeah, I know." The ^{U.S. F} stated that the search of the wheelchair revealed ^{NJ Ex Order 26.4(b)(1)} and ^{NJ Ex Order 26.4(b)(1)} that she removed from the unit.</p> <p>The NS further stated that she conducted a ^{NJ Exec Order} of both (Resident #2 and Resident #1 & #3's) rooms at that time, and no other ^{NJ Ex Order 26.4(b)(1)} were found. The ^{U.S. F} stated that after the incident, she contacted the ^{U.S. FOIA} who initiated ^{NJ Ex Order 26.4(b)(1)} for Resident #2, and the resident remained at her side for the first hour until she was able to assign the task to another staff member. The ^{U.S. F} stated that Resident #2 remained on ^{NJ Ex} for the remainder of their stay at the facility. The ^{U.S. F} reiterated that Resident #1 was not affected by the incident as the resident slept through the whole thing, and that she provided verbal education to Resident #3 regarding reporting this type of incident immediately in the future as ^{NJ Ex Order 26.4} was not allowed on the unit especially around the ^{NJ Ex Order 26.4(b)(1)} as that would be a ^{NJ Ex Order 26.4}.</p> <p>During a follow-up interview with the ^{U.S. FOIA} on 10/07/2025 at 2:10 P.M., she stated that no residents should have access to ^{NJ Ex Order 26.4(b)(1)} on the unit, especially around ^{NJ Ex Order 26.4(b)(1)}, which had the potential to ^{NJ Ex Order 26.4(b)(1)}. During the interview, the ^{U.S. FOIA} provided a list of residents highlighted on the ^{NJ Ex Order 26.4} Schedule and stated that on ^{NJ Ex Order 26.4(b)(1)}, a search of ^{NJ Ex Order 26.4(b)(1)}, and their rooms, was conducted.</p> <p>At that time, the surveyor reviewed the list which identified ten residents that were in ^{NJ Exec Order 26.4} of the ^{NJ Ex Order 26.4} contract due to having ^{NJ Ex Order 26.4(b)(1)} on their person and/or room. Additionally, the ^{U.S. FOIA} provided the surveyor with the initial ^{NJ Ex Order 26.4} Contracts signed by Resident #1, Resident #2, and Resident #3. The surveyor noted the signed contract for Resident #2 which indicated in section ^{NJ E} that, "I understand that my ^{NJ Exec C} and/or ^{NJ Exec Order} can be ^{NJ Exec Order 26.4} at any time for ^{NJ Ex Order 26.4} items." The surveyor then asked since the facility was aware of Resident #2's repeated violation of the ^{NJ Ex Order 26.4} contract/policy, if searches had been done prior to the incident on ^{NJ Ex Order 26.4(b)(1)} and the ^{U.S. FOIA} stated that they may have but she would have to check.</p> <p>No additional documentation was provided to the surveyor.</p> <p>On 10/10/2025 at 11:48 A.M., the surveyor attempted to verify the implementation of the facility's Removal</p>	F0689		

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F0689 SS = SQC-L	<p>Continued from page 10 Plan (RP) submitted to the New Jersey Department of Health (NJDOH) on 10/09/2025 at 5:09 P.M. At that time, the [U.S. FOIA] informed the surveyor that the facility did not have the education in the building, that the [U.S. FOIA (b) (6)] had the documents and was not at the facility. The surveyor was unable to verify the RP, and the [U.S. FOIA] was informed that the immediacy continued.</p> <p>An acceptable Removal Plan (RP) was received on 10/12/2025 at 5:52 P.M., indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice to include: the [U.S. F] immediately removed the [NJ Ex Order 26.4] from Resident #2; Resident #2 was searched, and NJ Ex Order 26.4(b)(1) and [NJ Ex Order 26.4(b)(1)] was [NJ Exec Order 26.4b1]; and Resident #2 was placed on [NJ Ex Order 26.4(b)(1)] until their discharge from the facility on [NJ Ex Order 26.4(b)(1)]. On [NJ Exec Order 26.4b1], the [U.S. F] educated Resident #2 and Resident #3 that [NJ Ex Order 26.4] was prohibited in a resident room. On 10/08/2025, nurse leaders began educating all residents who [NJ Ex Order 26] on the facility's [NJ Ex Order 26.4] policy and the dangers of [NJ Ex Order 26.4(b)(1)], and their rooms and equipment were searched by the [U.S. FOIA (b)] for violation of the [NJ Ex Order 26.4] policy. On 10/10/2025, the nurse leaders and [U.S. FOIA (b) (6)] re-educated all staff on the [NJ Ex Order 26.4] policy and the dangers of [NJ Ex Order 26.4(b)(1)].</p> <p>The surveyor verified the implementation of the RP on-site during the continuation of the survey on 10/14/2025 2:23 P.M.</p> <p>N.J.A.C. 8:39-27.1(a), 31.6(e)</p>	F0689		
F0838 SS = F	<p>Facility Assessment</p> <p>CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5)</p> <p>§483.71 Facility assessment.</p> <p>The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.</p>	F0838	<p>The Facility Assessment was reviewed by the Administrator/designee and corrected to include our resident population that was admitted to the facility with a history or current [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4] [redacted].</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>The [U.S. FOIA] was educated by the Administrator on 10/17/25 on the importance of ensuring the facility assessment is properly updated according to all State and Federal Guidelines, specifically to include our resident population that was admitted to the facility with a history or current use of, tobacco or drug and alcohol abuse. Administrator/Designee will audit monthly x3</p>	10/17/2025

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F0838 SS = F	Continued from page 11 §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or	F0838	Continued from page 11 months the facility assessment to ensure it is properly updated according to all State and Federal Guidelines. The Don/Designee will present the monthly findings to the monthly QAPI committee x3 months to determine necessity of future audits.	

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F0838 SS = F	<p>Continued from page 12 equipment to the facility during both normal operations and emergencies; and</p> <p>(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.</p> <p>§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).</p> <p>§ 483.71(b) In conducting the facility assessment, the facility must ensure:</p> <p>§ 483.71(b)(1) Active involvement of the following participants in the process:</p> <p>(i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and</p> <p>(ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.</p> <p>(iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.</p> <p>§483.71(c) The facility must use this facility assessment to:</p> <p>§483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).</p> <p>§483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population.</p> <p>§483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population.</p>	F0838		

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F0838 SS = F	<p>Continued from page 13</p> <p>§483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.</p> <p>§483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Complaint #2620207</p> <p>Based on interviews and review of other pertinent facility documentation on 10/07/2025 and 10/14/2025, it was determined that the facility failed to: a.) ensure that the facility-wide assessment (FA) evaluated its resident population and b.) identified the resources needed to provide the necessary care and services required for residents admitted with a history or current <u>NJ Ex Order 26.4(b)(1)</u>. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>Refer to F689</p> <p>A review of the facility's "Facility Assessment" provided by the <u>U.S. FOIA (b) (6)</u>, indicated that the assessment was completed on <u>NJ Ex Order 26.4(b)</u>. A further review of the facility's FA did not include any documentation that addressed the resident population that was admitted to the facility with a history or current <u>NJ Ex Order 26.4(b)(1)</u>.</p> <p>During a joint interview with the <u>U.S. FOIA</u>, the <u>U.S. FOIA (b) (6)</u>, and the <u>U.S. FOIA (b) (6)</u> on 10/14/2025 at 2:14 P.M., the <u>U.S. FOIA</u> stated that the FA was a snapshot of residents that included all departments involved in their care and a breakdown of demographics involving staffing and their care needs. The <u>U.S. FOIA</u> stated that it was more than just the physical needs required by the residents, but detailed needs that each resident would require. The <u>U.S. FOIA</u> further stated that the facility currently had <u>NJ Ex Order 26.4(b)(1)</u>. In the presence of the surveyor, the <u>U.S. FOIA</u> reviewed the FA and confirmed it did not identify <u>NJ Ex Order 26.4(b)(1)</u> as a category population that they served. The <u>U.S. FOIA</u> stated that an issue was identified involving <u>NJ Ex Order 26.4(b)</u> that affected all residents, and that the facility planned to update the FA accordingly.</p>	F0838		

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F0838 SS = F	Continued from page 14 NJAC 8:39-5.1(a)	F0838		

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F0000	<p>INITIAL COMMENTS</p> <p>An on-site revisit was conducted on 10/28/25 in relation to the 10/7/25 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p>	F0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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