State of New Jersey
DEPARTMENT OF HEALTH
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PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

JEFFREY A. BROWN
Acting Commissioner

IN RE: LICENSURE VIOLATION	:	
TRENTON GARDENS REHABILITATION AND NURSING CENTER	:	CURTAILMENT OF ADMISSIONS ORDER AND DIRECTED PLAN OF CORRECTION
(NJ Facility ID# NJ61113)	:	

TO: Benzion Friedman- Administrator
Trenton Gardens Rehabilitation and Nursing Center
512 Union Street
Trenton NJ 08611
bfriedman@trentongardensrehab.com

Dear Mr. Friedman:

As more fully detailed below, the New Jersey Department of Health (the Department) is issuing to Trenton Gardens Rehabilitation and Nursing Center (Trenton Gardens) a curtailment of new admissions, a curtailment of readmissions of any residents sent to a hospital for a drug overdose, and a Directed Plan of Correction (DPOC) requiring retention of both an Administrator Consultant and Registered Nurse Consultant.

The Health Care Facilities Planning Act (N.J.S.A. 26:2H-1 et seq.) (the Act) provides a statutory scheme designed to ensure that all health care facilities are of the highest quality. Pursuant to the Act and N.J.A.C. 8:43E-1.1 et seq. (General Licensure Procedures and Standards Applicable to All Licensed Facilities), the Commissioner of Health is authorized to inspect all health care facilities and

to enforce the Standards for Licensure of Long-Term Care Facilities set forth at N.J.A.C. 8:39-1.1 et seq.

LICENSURE VIOLATIONS:

Staff from the Department's Health Facility, Survey and Field Operations unit were on-site at Trenton Gardens Rehabilitation and Nursing Center on May 15, 2025 for complaint investigations. During the investigations, the surveyors identified numerous state violations, including:

1. The facility's failure to ensure residents had a right to a safe, clean and comfortable environment, pursuant to N.J.A.C. 8:39-31.4(a)-(f),
2. The facility's failure to ensure the resident's right to be free from abuse, pursuant to N.J.A.C. 8:39-4.1(a)(5),
3. The facility's failure to immediately report suspected or reported resident abuse, pursuant to N.J.A.C. 8:39-9.4,
4. The facility's failure to implement adequate written criteria for personnel actions that require disciplinary action, pursuant to N.J.A.C. 8:39-9.3(a),
5. The facility's failure to provide a resident with a proper discharge, pursuant to N.J.A.C. 8:39-4.1(a)(32),
6. The facility's failure to keep resident care plans up to date, pursuant to N.J.A.C. 8:39-11.2(e)(1)-(2),
7. The facility's failure to ensure the residents' environment remains as free of accident hazards as is possible, pursuant to N.J.A.C. 8:39-27.1(a), and
8. The facility's inability to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, pursuant to N.J.A.C. 8:39-9.2(a).

On October 12, 2024, at approximately 8:30 p.m., the Unit Manager on duty was notified by LPN #2 that Resident #15 had a scratch on his/her face. LPN #2 reported that Resident #8 left the room he/she shared with Resident #15, cursing and stating he/she punched Resident #15. The Director of Nursing (DON) spoke to both residents, but no follow-up investigation was conducted outside of a grievance filed for Resident #15. The facility failed to report the incident to the Department as well as to law enforcement.

On April 25, 2025, Resident #2 told LPN #1 that he/she was going to report her for raping Resident #3. LPN #1 was suspended, but the DON did not conduct interviews or assessments of the residents on LPN #1's assignment, and did not obtain witness statements from other staff that worked on the unit when the alleged sexual abuse occurred.

On May 8, 2025, at 12:46 p.m., Resident #16 had an incident with his/her roommate which led to a physical fight. Resident #16 did not return back to the facility, and his/her sister was notified by the DON via phone call that the resident would not be allowed back. At 1:44 p.m., the DON stated she considered the discharge a safe one because all of Resident #16's meds and electronic Medication Administration Record (eMAR) were given to the police as he/she left. Records show no documented evidence that a 30-day advanced notification was given to Resident #16 or his/her responsible party.

On February 21, 2025, April 1, 2025, and May 6, 2025, Resident #6 was found unresponsive, taken to the hospital, and diagnosed with an opioid overdosage. The facility did not update Resident #6's Care Plan to manage his/her substance abuse after the resident overdosed on February 21, 2025, April 1, 2025, or May 6, 2025.

On August 24, 2024, Resident #8 was found slumped over his/her wheelchair in front of a residence on Federal Street, profusely sweating, with slurred speech, and in possession of a black bag consisting of drug paraphernalia, white powder within a green vial, a green vial with clear liquid, multiple white folded small envelopes, three orange capsules, and Narcan. The resident was diagnosed with opiate overdose after a hospital visit.

Based on interviews, medical record reviews, and review of other pertinent facility documentation, it was determined that the facility failed to prevent illicit drugs from entering the facility and drug overdoses from occurring, ensuring thorough investigations were conducted for abuse and drug overdoses, and notifying the police and the Department when required. The facility's noncompliance represented a direct risk to all residents' physical and/or mental health within the facility.

CURTAILMENT OF ADMISSIONS:

As you were notified by telephone and email on May 20, 2025, effective immediately upon notification, the Department ordered the curtailment of admissions to the facility, including readmissions of any residents sent to a hospital for a drug overdose.

This enforcement action was taken in accordance with the provisions set forth at N.J.A.C. 8:43E-2.4 (Plan of Correction), 3.1 (Enforcement Remedies Available) and 3.6 (Curtailment of Admissions) in response to serious violations observed by Department staff during its on-site inspection as detailed above.

Please be advised that N.J.A.C. 8:43E-3.4(a)(2) provides for a penalty of $250 per day for each resident admitted to the facility in violation of this curtailment order.

DIRECTED PLAN OF CORRECTION:

The Commissioner of the Department of Health hereby directs the following plan of correction:

1. The facility must retain the full-time, on-site services of an Administrator Consultant, who shall be a New Jersey Licensed Nursing Home Administrator, to assist the facility to manage and oversee the facility's operation and to ensure the facility's Policies and Procedures are followed. The Administrator Consultant shall:

    a. Assess the facility's compliance with all applicable state licensing standards and identify areas of non-compliance;

    b. Oversee the development, implementation and evaluation of corrective action plans;

    c. Develop and implement compliance management systems at the facility;

d. Collaborate with facility leadership to ensure that operating procedures, systems and standards align with compliance requirements;

e. Ensure staff training and testing for competency needed to comply with applicable licensing standards, including, but not necessarily limited to, medication administration by certified medication aides; and,

f. Take other actions as may be necessary to ensure identification of compliance issues and implementation of timely corrective measures.

2. The facility must also retain the full-time, on-site services of a Director of Nursing (DON) consultant who is a Registered Nurse to oversee the care of the residents, including assessments of their conditions, ensuring Health Service Plans are created with interventions in place with goals for care and are evaluated for treatment and updated quarterly, ensuring General Service Plans are updated as needed and semi-annually, ensuring the Outbreak Response Policy is followed and the correct policies and procedures are implemented when a COVID outbreak occurs to ensure that all residents are kept informed and safe and to prevent the spread of infection.

The consultants shall have no previous or current ties to the facility's principals, management and/or employers or other related individuals of any kind, including, but not limited to employment, business, or personal ties. The consultants shall be present in the facility for no less than 40 hours per week until further notice from the Department, with documented coverage of all shifts and weekends.

The consultants shall be approved in advance by the Department. The facility shall provide the names and resumes of the proposed consultants by sending them to Kara.Morris@doh.nj.gov, Carol.Fogarty@doh.nj.gov, Arlene.McNinch@doh.nj.gov, Jeremiah.ike@doh.nj.gov, Lisa.King@doh.nj.gov, and Gene.Rosenblum@doh.nj.gov by 12 p.m. on May 28, 2025. The approved consultants shall be retained and begin work no later than the close of business on May 30, 2025.

Beginning on Friday, May 30, 2025, the facility should send weekly progress reports every Friday by 1:00 p.m. to Carol.Fogarty@doh.nj.gov and Arlene.McNinch@doh.nj.gov. These weekly reports shall include timely status updates regarding:

1. Identified areas of non-compliance;

2. Corrective measures to address identified areas of non-compliance; and,

2. Status of corrective measures implementation.

In addition, the facility is directed to maintain timely communication with the Department, as may be required.

Department staff will monitor facility compliance with this order and determine whether corrective measures are implemented by the facility in a timely fashion. Failure to comply with these and any other applicable requirements, as set forth in pertinent rules and regulations, may result in the imposition of penalties.

This Curtailment of Admissions Order and Directed Plan of Correction shall remain in place until the facility is otherwise notified in writing by a representative of this Department.

FORMAL HEARING

The facility is entitled to contest the curtailment, pursuant to N.J.S.A 26:2H-14, by requesting a formal hearing at the Office of Administrative Law (OAL). The facility may request a hearing to challenge any or all of the following: the factual survey findings and/or the curtailment. The facility must advise this Department within 30 days of the date of this letter if it requests an OAL hearing regarding the curtailment. Please forward your OAL hearing request to: Attention: OAL Hearing Requests Office of Legal and Regulatory Compliance, New Jersey Department of Health P.O. Box 360 Trenton, New Jersey 08625-0360 Corporations are not permitted to represent themselves in OAL proceedings. Therefore, if the facility is owned by a corporation, representation by counsel is required. In the event of an OAL hearing regarding the curtailment, the facility is further required to submit a written response to each and every charge as specified in this notice, which shall accompany its written request for a hearing. Failure to submit a written request for a hearing within 30 days from the date of this notice will render this a final agency decision. The final agency order shall thereafter have the same effect as a judgment of the court. The Department also reserves the right to pursue all other remedies available by law. Due to the emergent situation and the immediate and serious risk of harm posed to the residents, the Department will not hold the curtailment in abeyance during any appeal of the curtailment.

Thank you for your attention to this important matter and for your anticipated cooperation. If you have any questions concerning the Directed Plan of Correction, please contact Nadine Jackman, Office of Program Compliance, at Nadine.Jackman@doh.nj.gov.

Sincerely,

Gene Rosenblum, Director
Office of Program Compliance

Division of Certificate of Need and Licensing
GR:JI:nj
DATE: May 23, 2025
EMAIL: bfriedman@trentongardensrehab.com; gailerader@verizon.net
REGULAR AND CERTIFIED MAIL
RETURN RECEIPT REQUESTED
Control # X25130