STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 000	INITIAL COMMENTS COMPLAINT #: NJ14516; NJ142594; NJ144335 DATE: 4/5/21 CENSUS: 100 SAMPLE: 37 THE FACILITY WAS FOUND TO BE NOT IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART483,SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON A RECERTIFICATION SURVEY WITH COMPLAINTS.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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.	F 609		5/11/21

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

Electronically Signed | 04/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 609	Continued From page 1 §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: Based on observation, interview, and review of facility documents, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) an allegation of staff to resident abuse that occurred on 3/20/21. The deficient practice was identified for 1 of 3 residents reviewed for abuse (Resident #26) and was evidenced by the following: On 3/23/21 at 11:03 AM, the surveyor interviewed a Resident Advocate who stated that Resident #26 was involved in a verbal altercation with an Agency Nurse on [redacted] The Resident Advocate noted that the police were called to the facility regarding this incident by Resident #26. The Resident Advocate stated that the Nursing Supervisor/Registered Nurse (NS/RN) informed the nurse to leave the facility and not return. The Resident Advocate was unsure of the nurse's name because she was an Agency Nurse, but confirmed that the nurse had not been back to the facility since the incident. On 3/23/21 at 11:34 AM, the surveyor interviewed Resident #26, who stated that on Saturday, [redacted], there was an Agency Nurse who worked the 7:00 AM to 3:00 PM shift that came into his/her room and started " [redacted] and	F 609	F Tag- 609 1. The incident that occurred on [redacted] with resident #26 and the agency nurse was reported by the LNHA (Licensed Nursing Home Administrator) on 3/29/2021. The Corporate Consultant on 3/29/2021 provided individualized in-servicing to the Administrator and Director of Nurses as to the Policy and Procedure for Reportable events as well as the Abuse Policy. The incident was also reported to the staffing agency. 2. All residents have the potential to be affected by this deficient practice when an incident of abuse is not reported to the proper agencies. 3. The Director of Nurses as well as the Administrator in-serviced all staff members on 3/29/2021 as to the Policy and Procedure for reporting abuse and the Abuse Policy. A hand-out of the Abuse Policy was provided to each staff member. The Abuse Policy is included in the Employee Hire Packet. 4. The Director of Nurses, Assistant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 609	Continued From page 2 [redacted] him/her that they would not be administered his/her[redacted] medication. The resident stated that this nurse was not assigned to him/her after a concern he/she had about them [redacted] weeks prior, and that the NS/RN was his/her assigned nurse for that shift so there was no reason that the Agency Nurse should been in the resident's room. The resident stated that they had called the local police department, and the police officer came to the facility to file harassment charges, and provided the surveyor with the case number from the police officer. The resident stated that the Agency Nurse was told to leave the building but had resisted at first. The resident noted that the Licensed Nursing Home Administrator (LNHA) informed him/her that the Agency Nurse was banned from the building. The surveyor reviewed Resident #26's medical record. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected that the resident had a brief interview for mental status (BIMS) score of [redacted], indicating a [redacted]. On 3/29/21 at 11:16 AM, the surveyor interviewed the NS/RN via telephone, who stated that Resident #26 did not like the Agency Nurse and called the police department on her. The NS/RN said that the Agency nurse was "yelling" at both the resident and herself. The NS/RN stated that an investigation was not completed, but the LNHA was informed of the incident and that nurse was no longer permitted at the facility. On 3/29/21 at 12:13 PM, the surveyor interviewed	F 609	Director of Nurses, Unit Managers and Nursing Supervisor will monitor 5 employees daily x 30 days for verbal return competencies on the Abuse Policy, then 3 employees x 30 days, then 3 employees monthly x 30 days. All findings will be reviewed at the Quality Assurance meeting x 3 quarters	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 609	Continued From page 3	F 609		

the LNHA, who stated that he was informed of the situation that occurred on [redacted] between the Agency Nurse and Resident #26. The LNHA said that upon surveyor questioning for the investigation, was when he realized the event was not investigated and at that time, reported it to the NJDOH. The LNHA stated that events were reported to the NJDOH based on the NJDOH facility reportable event grid.

On 3/29/21 at 12:35 PM, the surveyor interviewed the Director of Nursing (DON), who stated that she was not at the facility during the incident, but she was briefed on the incident. The DON said that she was informed that the Agency Nurse was"not very nice" and would not return to the facility. The DON stated that if a staff member was "not being nice to a resident," it would be considered abuse.

On 3/30/21 at 8:37 AM, the Regional Director informed the survey team that after the surveyor inquiry, the incident on [redacted] between the Agency Nurse and Resident #26 was investigated and reported to the NJDOH on [redacted]

A review of the local police department report dated [redacted] provided by the facility included that the resident reported to the police officer that he/she was [redacted]" by a staff member. The staff member was identified as the Agency Nurse. The report also included that the police officer spoke with the NS/RN, who corroborated the resident's statement. The police officer noted in the report that the Agency Nurse was asked several times to lower her voice or "discontinue the use of vulgar language in front of residents." The police officer noted that the Agency Nurse was uncooperative with him during the entire time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 609	Continued From page 4 speaking with her. On 4/5/26 at 9:26 AM, the LNHA, in the presence of the Regional Director, Regional Minimum Data Set Nurse, DON, and the survey team, confirmed that the incident on [redacted] between the Agency Nurse and Resident #26 should have been reported to the NJDOH. A review of the facility's undated Abuse policy included that "abuse" allegations (abuse, neglect, exploitation, or mistreatment) are reported to Federal and State Law. The facility will 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 no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury to the administrator of the facility and to other officials (including 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 procedure. N.J.A.C. 8:39-4.1(a)5	F 609		
F 610 SS=D	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,	F 610		5/11/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 610	Continued From page 5 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: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to investigate an allegation of staff to resident abuse that occurred on [redacted]. This deficient practice was identified for 1 of 3 residents reviewed for abuse (Resident #26) and was evidenced by the following: On 3/23/21 at 11:03 AM, the surveyor interviewed a Resident Advocate who stated that Resident #26 had a verbal altercation with an Agency Nurse on [redacted] The Resident Advocate noted that the police were called to the facility regarding this incident by Resident #26. The Resident Advocate stated that the Agency Nurse had to leave the facility and was told to not return, so the Nursing Supervisor/Registered Nurse (NS/RN) had to care for her assigned residents. The Resident Advocate was unsure of the nurse's name because she was an Agency staff member. On 3/23/21 at 11:34 AM, the surveyor interviewed Resident #26, who stated that on Saturday, [redacted] there was an Agency Nurse who worked the 7:00 AM to 3:00 PM shift that came into his/her room and started [redacted] and	F 610	F-Tag 610 1. The Corporate Consultant on 3/29/21 provided individualized counseling and in-serviced the Licensed Nursing Home Administrator (LNHA) as well as the Director of Nurse in regards to the Policy and Procedure for Investigating and Reporting accidents or incidents. The facility Chain of Command was reviewed and updated by the Corporate Consultant and an in-service was provided to the LNHA (Licensed Nursing Home Administrator) and the Director of Nurses. 2. All residents have the potential to be affected by this deficient practice when an accident or incident is not reported and/or investigated in a timely manner and within the guidelines of the facility's policy. 3. An in-service was done with all staff members on 4/6/2021 by the Director of Nurses and Licensed Nursing Home Administrator in regards to the Policy and Procedure for Investigation and reporting Incidents and Accidents. An in-service	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 610	Continued From page 6 [redacted] him/her that they would not be administered his/her pain medication. The resident stated that this nurse was not assigned to him/her after a concern he/she had about them three weeks prior, and that the NS/RN was his/her assigned nurse for that shift so there was no reason that the Agency Nurse should been in the resident's room. The resident stated that they had called the local police department, and the police officer came to the facility to file harassment charges, and provided the surveyor with the case number from the police officer. The resident stated that the Agency Nurse was told to leave the building but had resisted at first. The resident noted that the Licensed Nursing Home Administrator (LNHA) informed him/her that the Agency Nurse was banned from the building. The surveyor reviewed Resident #26's medical record. A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care date[redacted] reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] indicating a [redacted]. On 3/29/21 at 11:16 AM, the surveyor interviewed the NS/RN via telephone, who stated that Resident #26 did not like an Agency Nurse and called the police department on her. The NS/RN said that the Agency nurse was "yelling" at both the residents and herself. The NS/RN stated that an investigation was not completed, but the LNHA was informed of the incident and that nurse was no longer permitted at the facility. On 3/29/21 at 12:13 PM, the surveyor interviewed	F 610	was done with all staff members by the Director of Nurses on 4/6/2021 in regards to the Chain of Command and how it applies to all reporting of accidents and incidents. 4. The Licensed Nursing Home Administrator (LNHA) and the Director of Nurses will review all accidents and incidents within 24 hours of occurrence and determine the need of further investigation and reporting to the proper government agencies ongoing. The Director of Nurse, Unit Managers and Nursing Supervisor will review daily each incident and accident report ongoing. All findings will be reviewed at the Quality Assurance meeting x 3 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 610	Continued From page 7	F 610		

the LNHA, who stated that he was in charge of investigations making sure all investigations were complete with witness statements, speaking to the resident, and anyone else that was involved in the incident. The LNHA stated both witnessed, and unwitnessed incidents were investigated, including allegations of abuse. The LNHA confirmed that he was informed of the situation that occurred on [redacted] between the Agency Nurse and Resident #26 that day by the NS/RN. The LNHA stated that upon surveyor questioning for the investigation, was when he realized the incident was not investigated. The LNHA acknowledged that it was his responsibility to make sure the incident was investigated.

On 3/29/21 at 12:35 PM, the surveyor interviewed the Director of Nursing (DON), who stated that she was not at the facility during the incident, but she was briefed on the incident. The DON said that she was informed that the Agency Nurse was"not very nice" and would not return to the facility. The DON stated that if a staff member was "not being nice to a resident," it would be considered abuse. The DON stated that she was not responsible for investigations but confirmed that this incident should have been investigated.

On 3/30/21 at 8:37 AM, the Regional Director informed the survey team that after the surveyor inquiry, the incident on [redacted] between the Agency Nurse and Resident #26 was investigated and reported to the NJDOH on [redacted]

A review of the local police department report dated 3/20/21 provided by the facility included that the resident reported to the Police Officer that he/she was [redacted]" by a staff member. The staff member was identified as the Agency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 610	Continued From page 8	F 610		

Nurse. The report also included that the Police Officer spoke with the NS/RN, who corroborated the resident's statement. The Police Officer noted in the report that the Agency Nurse was asked several times to lower her voice or "discontinue the use of vulgar language in front of residents." The Police Officer noted that the Agency Nurse was uncooperative with him during the entire time speaking with her.

A review of the facility's Accidents and Incidents - Investigating and Reporting Policy dated 1/5/21 included that all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. The policy continued that the Nursing Supervisor/Charge Nurse and/or department director or supervisor shall promptly initiate and document the investigation of the accident and incident. The policy included the following information, if applicable, should be included in the investigation; time and date of the incident; circumstances surrounding the incident or accident; where the incident or accident took place; the names of witnesses and their accounts of the accident or incident; the injured person's account of the accident or injury; the time and date the injured person's Attending Physician and family were notified; any corrective action taken; follow-up information; and other pertinent data as necessary or required. The policy also included that the Nurse Supervisor/Charge Nurse or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the DON within twenty-four hours of the incident or accident.

N.J.A.C. 8:39-4.1(a)5; 27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		5/11/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 842	Continued From page 10 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint #NJ144335 Based on interview, record review, and other facility documentation, it was determined that the facility failed to maintain an accurate, complete, and easily accessible medical record for 1 of 6 closed medical records reviewed (Resident #103). This deficient practice was evidenced by the	F 842	F Tag -842 1. The Corporate Consultant on 4/6/2021, provided individualized in-servicing to the Director of Medical Records on the policy and procedure on the Retention of medical records. The form to record bowel elimination was re-designed to reflect an individual record for each resident and will be maintained as part of their medical record. All nurses were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 842	Continued From page 11 following: On 3/30/21 at 9:50 AM, the surveyor began reviewing the closed medical record for Resident #103. A review of the admission record reflected that the resident was admitted to the facility after a [redacted] day stay in the hospital in [redacted]. A review of the Cumulative Diagnoses Record reflected the resident was admitted to the facility with [redacted]. A review of the New Jersey Universal Transfer form dated [redacted] at 7:45 PM reflected that the resident was being transferred from the facility to the hospital emergency room (ER) for [redacted] and complaining of [redacted]. A review of the Clinical Notes reflected a Nurses Note dated [redacted] with no time indicated that the resident was noted to be [redacted] and complaining of [redacted] requesting to go to the ER. An additional Nurses Note dated [redacted], with a start time of 3:00 PM, reflected that the resident had [redacted] ml) of [redacted] At 5:00 PM, a call was made to the ambulance transport company, who responded that they would be at the facility in an hour. At	F 842	in-serviced on the new resident form for bowel elimination tracking. The policy was reviewed and revised by the Administrator, Director of Nurses and Medical Director. 2. All residents have the potential to be affected by this deficient practice when medical records are not complete, accurately documented, readily accessible and systematically organized. 3. An in-service was done by the Director of Nurses on 4/8/2021 with all nurses in regards to the policy and procedure of Medical Records, an in-service was done with all nurses by the Assistant Director of Nurses on 4/8/2021 in regards to the new Resident Bowel Elimination form that will be utilized for each individual record. 4. The Assistant Director of Nurses and Unit Managers will monitor daily x 30 days the Resident Bowel Elimination record to ensure that all recordings are accurate. The Director of Medical records will review each closed medical record to ensure all information is complete and retained x 7 years. All findings will be reviewed at the Quality Assurance meeting x 3 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 842	Continued From page 12	F 842		

7:00 PM, a follow-up call was made to the ambulance transport company, who responded that they would be at the facility in twenty minutes. At 7:45 PM, the ambulance transport company arrived. At 7:50 PM, the resident became [redacted] and [redacted] was started. At 8:15 PM, the Paramedics arrived at the facility and continued with [redacted]

A review of a Dietary Progress Note dated 10:54 PM reflected that a follow-up call was made to the emergency room and that the resident was pronounced dead at 9:17 PM in the ER.

On 3/30/21 at 11:09 AM, the surveyor interviewed the Licensed Practical Nurse (LPN), who confirmed that she was the resident's nurse on [redacted] The LPN stated that the resident complained of [redacted], but she completed [redacted] assessment. The LPN stated that the resident did not have a [redacted] when he/she tried; There was a [redacted] on the sheets from trying.

On 3/30/21 at 1:20 PM, the surveyor interviewed the Registered Nurse (RN) via telephone, who confirmed that she was the resident's nurse on [redacted] on the 3:00 PM to 11:00 PM nursing shift. The nurse stated that the resident was complaining of [redacted] and was waiting for ambulance transportation to the ER. The RN stated that she conducted no [redacted] assessment and that the resident had no [redacted].

On 3/30/21 at 2:08 PM, the survey team requested from the Regional Director/LPN (Regional Director) a copy of the resident's [redacted] and [redacted] log for the month of [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 842	Continued From page 13 On 3/31/21 at 8:37 AM, the Regional Minimum Data Set/LPN (Regional MDS/LPN) in the presence of the Director of Nursing (DON), Licensed Nursing Home Administrator (LNHA), Regional Director, and the survey team submitted a document to the survey team. The document contained the resident's last name, room number, three rows, and columns with the first column with the letters [redacted] and [redacted] in their own row, respectively. The document had no title, no key, no date; The remaining information was blanked out. The month of February was handwritten in pen ink over the blanked out information. When the survey team asked what the document was or why the rest of the information was covered up, the Regional Director stated that it was the [redacted] Record and that the rest of the information was covered up for Health Insurance Portability Accountability Act (HIPPA) privacy reasons since the residents were not included in the surveyor's sample. At this time, the Administration Team was informed that HIPPA did not apply to the survey process, the facility was unaware of who was included in the survey, and that every resident in the facility could be sampled. The survey team requested a copy of the complete [redacted] Record. On 4/5/21 at 9:31 AM, the Regional MDS/LPN provided the survey team with the [redacted] Record dated [redacted] The comparison of the two forms was as followed:	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 842	Continued From page 14	F 842		

Record #1, which was incomplete, provided by the facility on [redacted], contained the resident's name handwritten in all capital letters with the resident's room number typed above the name. The rows were identified for each shift, being day, evening, and night accordingly. The columns were identified as each day of the month. It was documented that the resident's [redacted] were recorded until [redacted] for the day shift and that the resident expired. The resident left the facility on [redacted] during the evening shift.

Record #2, which was provided by the facility on 4/5/21, contained the resident's name handwritten, but only the first letter of the name was capitalized. The record also did not contain the resident's room number like Record #1. Record #2 indicated that the resident's [redacted] were recorded unti[redacted] during the night shift. The document indicated the resident had expired. (The resident left the building on [redacted] during the evening shift. This document also did not include [redacted] like Record #1).

Record #1 indicated on [redacted] the resident had a [redacted] during the day shift, a [redacted] during the evening shift, and a [redacted] during the night shift. According to Record #2, on [redacted] the resident had a [redacted] during the day [redacted] during the evening shift, and no [redacted] during the night shift. The [redacted] during the night shifts contradicted each other.

Record #1 indicated that on [redacted], the resident had a [redacted] during the day shift, a [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 842	Continued From page 15	F 842		

during the evening shift, and no [redacted] during the night shift. According to Record #2, on [redacted], the resident had a [redacted] during the day shift; and [redacted] for both the evening and night shift. The two bowel movements on Record #1 contradicted the interviews from both nurses; the [redacted] on Record #2 contradicted the interview with the LPN, and both records did not match.

On 4/5/21 at 10:30 AM, the surveyor reviewed the two [redacted] Records with the Regional MDS/LPN, noting the discrepancies. The Regional MDS/LPN stated that she thought it was the same sheet that she provided to the survey team. The Regional MDS/LPN stated that she had just folded up Record #1 to copy, but she would provide the survey team with the original.

On 4/5/21 at 11:31 AM, the survey team interviewed Human Resources (HR), who stated that she was responsible for maintaining medical records. HR stated that she had to maintain records for residents who no longer resided in the building for three years. HR stated that the DON was responsible for maintaining records that contained multiple residents.

On 4/5/21 at 12:04 PM, the survey team interviewed the DON, who stated that the Unit Manager usually maintained assessments but confirmed the facility currently did not have a Unit Manager.

On 4/5/21 at 12:07 PM, the LNHA joined the DON and survey team. The DON continued that resident [redacted] records were not individual, so they were not included in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 842	Continued From page 16 resident's chart, but that would be important information to be kept with the resident's medical record. The survey team reviewed the [redacted] Elimination Records with the DON and LNHA. They both agreed that the documents were two different records and confirmed the discrepancies. The LNHA stated that it looked like the sheet might have been lost, and someone tried to duplicate it. The LNHA confirmed that medical records should never be recreated and that the records should be accurate. On 4/5/21 at 12:50 PM, the survey team exited the facility with the full content of Record #1 not produced. A review of the facility's retention of Medical Records, dated reviewed 1/5/21, included that medical records shall be retained by the facility in accordance with current applicable laws. Medical records of a discharged resident will be retained for a period of seven years. Refer F684	F 842		
F 880 SS=D	N.J.A.C. 8:39-35.2(d); 16(e) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		5/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 880	Continued From page 17	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 880	Continued From page 18 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other pertinent facility documentation, it was determined the facility staff members failed to a.) don (apply) Personal Protective Equipment (PPE) to enter the rooms of residents on Transmission-based precautions (TBP); and, b.) maintain appropriate infection control practices regarding a housekeeping cart. This deficient practice was identified for 3 of 52 (Resident #59, #27 and #29) for [redacted] unit and, 1 of 2 active nursing units ([redacted] Floor). The deficient practice was evidenced by the following: 1) On 3/24/21 at 1:24 PM, the surveyor observed Resident #59's room on [redacted] hall. Resident #59's room was observed with a stop see nurse sign - on Transmission Based Precautions, and how to don and doff (remove) PPE sign; a PPE bin in	F 880	F-tag-880 1. The Director of Nurses on 3/25/2021 provided individual counseling and in-serviced CNA#1, TNA #1 and TNA #2 and CNA #2 on the policy and procedure for donning and doffing PPE when entering a resident's room who is PUI (Person Under Investigation). The Director of Housekeeping on 3/25/2021 provided individual counseling to the housekeeper #1 who brought the housekeeping car and into resident #207 room. The Director of Housekeeping reviewed the policy of Equipment Use and Storage of Cleaning Carts with Housekeeper #1. A RCA (Root Cause Analysis) was started by the Management team to discover the cause of the event and to make corrective actions. It was discovered that the staff required review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 880	Continued From page 19 front of the door with PPE gowns, gloves, face shields, respirator masks and surgical masks. The surveyor observed Resident #59 self-propelling around the room in a wheelchair with no mask on. The surveyor observed a certified nursing assistant (CNA#1) wearing a surgical mask and no other PPE, inside Resident #59's room. CNA#1 was assisting Resident #59 find something. CNA#1 was observed with no PPE on and only a surgical mask, going through personal clothes in drawers, moving around plastic container bins and a blue suitcase, going through blankets and pillows on top of the resident's dresser and on her hands and knees on the floor looking under the bed. Resident #59 had briefly been in close proximity and at one point had their left hand on CNA#1's shoulder. A review of the facility face sheet revealed Resident #59 had been admitted to the facility in [redacted] with diagnoses that included but were not limited to [redacted] Review of Resident #59's physician's orders revealed an order dated [redacted] times a week. Review of Resident #59's Care Plan, on-going, revealed a problem list with an entry of "transmission-based precautions [redacted] secondary to [redacted]." On 3/24/21 at 1:44 PM, CNA#1 stated she had worked at the facility for seven years. CNA#1 stated she only had a surgical mask on because Resident #59 was only under investigation because they go to appointments in and out of the facility; CNA#1 stated she did not need any other PPE. CNA#1 stated Resident #59 went to dialysis and was on TBP. CNA#1 further stated she would identify residents on precautions by	F 880	of policies and procedures for [redacted] compliance including donning and doffing of PPE. 2. All residents have the potential to be affected by this deficient practice when staff do not follow the policy and procedure for Infection Control when donning and doffing PPE in a [redacted] room. All residents have the potential to be affected when housekeeping staff do not follow the policy for the Use and Storage of Cleaning carts. 3. The Infection Preventionist on 3/25/2021 in-serviced all CNAs and TNAs on the Policy and procedure for donning and doffing of PPE with regards to residents in PUI rooms. The Housekeeping Director on 3/25/2021 in-serviced all housekeeping staff on the policy and procedure of Use and Storage of Cleaning carts. During the RCA (Root Cause Analysis) the management team discover that there were certain areas of clarity in regards to infection control with regards to donning and doffing PPE and re-education to the Housekeeping staff in regards to Use and Storage of Housekeeping carts and the placement of these carts outside the resident's room. It was discovered during the RCA that staff needed in-servicing in policies and procedures for Infection Control. CNA #1, TNA#1 and TNA #2 and Housekeeper #1 viewed the mandatory regulatory video '[redacted] All Topline staff as well as IP (Infection preventionist) viewed CDC/Train Module #1 as well as the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 880	Continued From page 20 asking the nurse, by the signs on the door and the PPE bin by the door. CNA#1 stated TBP means she should have worn a PPE gown, goggles, gloves but that she did not have to wear any N95 or KN95 mask. CNA#1 reported to the nursing administration after the observation. On 3/24/21 at 1:50 PM, the Licensed Practical Nurse (LPN#1) caring for Resident #59, stated the nurses would inform the CNAs about any residents on precautions and what PPE to wear into the TBP rooms. The LPN stated going into Resident #59's room the staff needs to wear a KN95 mask with a surgical mask over it, PPE gown, gloves, and eye protection to protect the resident and staff from exposure to infections. On 3/24/21 at 1:53 PM, the Assistant Director of Nursing (ADON#1) stated that Resident #59 was on TBP for [redacted] and all staff had to wear full PPE in the room to stop the spread of infection. On 3/25/21 at 6:10 AM, the surveyor observed a staff member in Resident #59's room wearing a gray cloth mask pulled down which exposed her nose and mouth, standing between the two resident beds and talking to Resident #59; The staff member began to exit the room when the surveyor approached her. The staff member was identified as a CNA#2. On 3/25/21 at 6:11 AM, CNA#2 stated Resident #59 was on precautions because they went to dialysis and would be among other people. CNA#2 stated Resident #59 did not have [redacted], so the staff just had to be aware that the resident went out of the facility. CNA#2 stated that a daytime supervisor had told her she did not need	F 880	mandatory regulatory videos of [redacted] and Use and Storage of PPE.All staff as well as Frontline staff and Topline staff and Infection preventionist (IP) including Maintenance, dietary and Therapy, viewed CDC/Train Module #6-B as well as mandatory regulatory videos of "[redacted] and "Use and Storage of PPE". Module 11-B on CDC/ Train (Enviromental Cleaning and Disinfecting) was viewed by all staff including Topline and Infection Preventionist (IP). 4. The Administrator, Director of Nurses and Assistant Director will make daily rounds on the PUI unit to ensure that all staff members are donning and doffing the correct PPE x 30 days . The Housekeeping Director will make daily rounds and ensure that all housekeeping staff are following the policy for Use and Storage of Housekeeping Carts x 30 days. All findings will be reviewed at the Quality Assurance meeting x 3 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 880	Continued From page 21	F 880		

to wear anything in the room but could not recall the supervisor's name. CNA#2 further stated she would identify an isolation room by the signs on the door and the bin with PPE in it. CNA#2 stated PPE was used to stop infection.

On 3/25/21 at 6:12 AM, a staff member walked past the surveyor and CNA#2 and into Resident #59's room. The staff member was identified as a temporary nursing assistant (TNA#1) and was observed wearing a surgical mask and no other PPE and was carrying two pink pitchers into the room.

On 3/25/21 at 6:12 AM, TNA#1 stated she had been at the facility for one month and she had education on TBP and PPE. TNA#1 stated she would identify an isolation room by the PPE bin and sign outside the room. TNA#1 stated the purpose of the isolation and PPE, was so they did not spread infection to others.

On 3/25/21 at 6:20 AM, the Registered Nurse (RN) on the second floor, stated that all staff were made aware of isolation rooms during shift report and there were signs and PPE bins at the doors. The RN stated that staff should wear N95 mask, surgical masks over it, PPE gown, gloves, and eye protection into the TBP room to protect themselves and the residents. The RN immediately removed CNA#2 and TNA#1 away from the residents and re-educated them.

On 3/25/21 at 6:35 AM, ADON #2 stated staff would identify isolation rooms by the PPE carts and signs on the door and by communication with the nurse. ADON #2 stated the staff must wear N95 mask with a surgical mask over it, PPE gown, gloves, and eye protection. The ADON #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 880	Continued From page 22	F 880		

further stated it did not matter why staff would be entering the TBP room, they were required to wear full PPE.

On 3/25/21 at 6:40 AM, the Licensed Nursing Home Administrator (LNHA) stated resident precautions were on the resident care plans. The LNHA stated all staff have access to the care plans and that staff would be given a verbal report during shift change regarding who was on precautions.

2) On 3/25/21 at 7:45 AM, the surveyor observed TNA#2 wearing a surgical mask and carrying a breakfast tray, walk into Resident #27's and Resident #29's room. TNA #2 did not don PPE gown, gloves, N95 mask or eye protection. The surveyor observed Resident #27's and Resident #29's room with a stop see nurse - on TBP and how to don and doff PPE signs; and a bin with PPE gowns, gloves, surgical masks N95 masks, and face shields. LPN #2 was standing outside of Resident #27's and Resident #29's room and she immediately removed TNA#2 out of the TBP room and educated her. TNA #2 exited the room, performed hand hygiene, and donned N95 mask, surgical mask, PPE gown, gloves, and a face shield.

On 3/25/21 at 7:47 AM, TNA #2 stated she had worked at the facility 1 month and that she would identify an isolation room by the sign on the door and the PPE bin outside the room. TNA #2 stated she had been educated on TBP and PPE but that she "just forgot" to don PPE. TNA #2 stated the purpose of wearing PPE into the TBP room was because of infection.

A review of the facility face sheet revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 880	Continued From page 23	F 880		

Resident #27 had been admitted in [redacted] with diagnoses that included but were not limited to [redacted]. Review of the care plan, on-going, revealed Resident #27 left the facility for [redacted] a week and would be considered [redacted] UI secondary to [redacted]

A review of the facility face sheet revealed Resident #29 had been admitted in [redacted] and readmitted in [redacted] Resident #29 had diagnoses that included but were not limited to [redacted]. Review of the care plan, on-going, revealed Resident #29 left the facility for [redacted] a week and was on Transmission-Based Precautions/[redacted] precautions secondary to [redacted]

On 3/25/21 at 9:49 AM, the Director of Nursing (DON) stated the [redacted] residents were put on [redacted] and TBP, droplet and airborne, and all staff were expected to wear N95 mask with a surgical mask over it, eye protection, PPE gown and gloves, and optional hair bonnet into the resident's room.

On 3/25/21 at 9:55 AM, the facility regional representative stated staff were expected to don PPE prior to entering any resident room on TBP to provide care or if they will be less than 6 feet from the resident. The regional representative stated the "guidance" was that if staff would come in contact with the resident or if delivering meal tray or water pitchers, the staff should be in PPE.

On 3/25/21 at 12:58 PM, the facility regional representative stated we have done numerous in-services on PPE for the staff. The facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 880	Continued From page 24	F 880		

regional representative further stated the dialysis residents were on TBP, so we expect the staff to wear full PPE N95 mask with a surgical mask over it, eye protection, gown, and gloves. We do not allow cloth masks to be worn by the staff.

A review of a facility in-service which included but was not limited to Isolation Precautions, dated [redacted] revealed that CNA#1 and CNA#2 had attended. The facility included the in-service inserts which included but was not limited to, Use PPE When Caring for Patients with Confirmed or Suspected [redacted],not dated.

A review of the facility provided, Use PPE When Caring for Patients with Confirmed or Suspected [redacted] revealed instructions which included but were not limited to PPE must be donned correctly before entering the patient area (isolation room) and PPE must remain in place and be worn correctly for the duration in potentially contaminated areas.

3. On 3/23/21 at 11:33 AM, the surveyor observed resident room [redacted]; a well non-ill room, with a housekeeping cart inside the doorway, outside of the resident's bathroom entrance. Housekeeper #1 was inside the resident's room cleaning.

On 3/24/21 at 9:46 AM, the surveyor observed resident room [redacted]; a well non-ill room, with a housekeeping cart inside the doorway, outside of the resident's bathroom entrance. Housekeeper #1 was observed inside the resident's room mopping the floor. The surveyor interviewed the Housekeeper who stated that the housekeeping cart was allowed to be inside the resident's room in the doorway.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 880	Continued From page 25	F 880		

On 3/24/21 at 9:51 AM, the surveyor interviewed Housekeeper #2 who stated that housekeeping carts were never allowed inside a resident's room. The carts needed to remain in the hallway outside the resident's door.

On 3/24/21 at 9:58 AM, the surveyor interviewed the Housekeeping Director who stated that the housekeeping cart either remained in the hallway outside the resident's door or inside the resident's room by the doorway. The Housekeeping Director stated that the housekeeping cart should never go into an isolation room; Housekeeper #1's cart was removed for cleaning.

On 3/24/21 at 10:09 AM, the surveyor interviewed the Regional Director/Infection Preventionist Licensed Practical Nurse who stated that housekeeping carts should remain in the hallway outside the resident's room. The housekeeping cart should not enter into a resident's room because the room would be considered dirty, and the cart would be contaminated so when the cart was brought into another room, it transferred germs to that room. The Regional Director stated that the facility probably has a policy for cleaning housekeeping carts, but housekeeping carts should not be brought in the room.

On 3/24/21 at 10:35 AM, the Regional Director provided the surveyor with Equipment Use and Storage of Cleaning Carts policy dated 3/24/21; which the Regional Director stated she just initiated this policy. A review of this policy included that the cleaning cart is to be maintained outside of a resident's room in eyesight at all times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

(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
F 880	Continued From page 26 N.J.A.C. 8:39-19.4; 27.1	F 880		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315454	A. Building 01 - MAIN BUILDING 01 B. Wing	6/29/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

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 Reg. # NFPA 101 LSC K0355	Correction Completed 05/11/2021	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	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	
4/5/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315454 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT 6/29/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

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 F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 05/11/2021	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	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 4/5/2021	☐ 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
656002 Y1	A. Building B. Wing Y2	6/29/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

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 S0670 Reg. # 8:39-7.2 LSC	Correction Completed 05/11/2021	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	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	
4/5/2021	☐ 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
656002 Y1	A. Building B. Wing Y2	6/29/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

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 S0670 Reg. # 8:39-7.2 LSC	Correction Completed 05/11/2021	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	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 4/5/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			