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	315454	A. BUILDING _____ B. WING _____	C 02/14/2025

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SHORE GARDENS REHABILITATION AND NURSING CENTER	**231 WARNER STREET TOMS RIVER, NJ 08755**

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F 000	INITIAL COMMENTS Complaint #: 169551, 169664, 171379, 172311, 175440, 175662, 177276, 177818, 181054, 181847, 182524, 182687 Survey Date: 2/14/25 Census: 141 Sample: 28 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		3/11/25

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

Electronically Signed | 03/07/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the residents' dining experience was provided in a manner to promote dignity and respect of the residents. This deficient practice was observed in 1 of 3 dining rooms on 2/13/25, and was evidenced by the following: On 2/13/25 at 12:16 PM, the surveyor observed the lunch meal on the Third-floor nursing unit in the dayroom/dining room. On each of the 14 residents, the staff served the cold beverages composed of milk and cranberry juice in disposable plastic cups. During an interview with the survey team on 2/14/25 at 11:00 AM, the US FOIA (b)(6) [redacted]	F 550	1. "The third-floor unit manager was educated on resident rights and educated that the residents should not be drinking from disposable plastic cups. 2. " All residents have the potential to be affected by this deficient practice. 3." The unit manager will ensure that the residents are served in a manner that promotes dignity and respect. " The Unit manager will check the third floor dining room during meal times to ensure the residents are dining with respect and dignity. The Unit Manager will audit the dining room 3x a week for 12 weeks to ensure	

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F 550	Continued From page 2 ([redacted] did not refute the identified concerns for dignity in using disposable plastic cups for the memory care residents. A review of the facility provided "Assistance with Meals" policy dated revised March 2022, included meal assistance to residents with attention to safety, comfort and dignity... The policy did not include the use of non-disposable dinnerware. NJAC 8:39-4.1(a)12	F 550	the residents are drinking out of drinkware that promotes respect and dignity. 4.The results of audits completed will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 182687 Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident was provided a [redacted] to prevent NJ Exec Order 26.4b1 This deficient practice was identified for 1 of 28 residents reviewed for resident rights (Resident #132), and was evidenced by the following: A review of the Admission Face Sheet revealed that Resident #132 was admitted to the facility	F 557	1. "The Unit Managers were educated that if a resident requests a [redacted] for their belongings, then they should put the request in through [redacted] and the facility will purchase a lock and the Maintenance team will install the [redacted] "The US FOIA (b)(6) was in serviced that the facility provides locks for residents who request them. 2. "All residents have the potential to be affected by this deficient practice.	3/4/25

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F 557	Continued From page 3 with diagnoses that included but were not limited to: NJ Exec Order 26.4b1 [redacted] A review of the Minimum Data Sheet (MDS), an assessment tool, revealed the resident was NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 for activities of daily living (ADL). During an interview with Resident #132 on 2/12/25 at 10:00 AM, the resident stated that when they were moved to a new room, they requested a [redacted] to be placed on the closet door to prevent other NJ Exec Order 26.4b1 [redacted]. The resident further stated that at times, they woke up in the morning and the closet was opened. The resident was unable to remember date they were relocated. At that time, the surveyor observed the resident's closet, and observed there was NJ Exec Order 26.4b1 in place. During an interview with the US FOIA (b)(6) [redacted] on 2/13/25 at 9:38 AM, the US FOIA (b)(6) stated that she was verbally notified of [redacted] requests. The US FOIA (b)(6) further stated that maintenance was notified of work orders through computer system called ' [redacted] and that the facility no longer kept physical logbooks for maintenance. The US FOIA (b)(6) stated that when residents requested [redacted] the facility installed the [redacted] but the family or resident needed to provide the [redacted] The US FOIA (b)(6) [redacted] provided a document titled "Direct Supply [redacted] Work Order # [redacted] The document revealed that Resident #132 requested a [redacted] to be placed on their NJ Exec Order 26.4b1 but the [redacted] nor the hardware was placed on the closet door.	F 557	3.The maintenance team and unit managers were in serviced that all residents have the right to a lock on their personal belongings. If a resident asks for a lock the nursing team will put the request in through [redacted] and the facility will purchase and install the lock. 4.The Maintenance Director will audit [redacted] monthly and the results of audits completed will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 557	Continued From page 4 During an interview with the US FOIA (b)(6) on 2/13/25 at 12:44 PM, the US FOIA (b)(6) stated that the facility provided the hardware for the NJ Exec Ord and the family or resident provided the NJ Exec Ord The US FOIA (b)(6) stated that he was notified of the requests through a work order that was placed in the NJ Exec Order 2 system. During an interview with the US FOIA (b)(6) on 2/13/25 at 1:00 PM, the US FOIA (b)(6) indicated that the facility did not provide NJ Exec Ord for residents.	F 557		
F 584 SS=F	NJAC 8:39-4.1(a)15 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		4/3/25

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F 584	Continued From page 5 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documentation it was determined that the facility failed to provide a safe, clean and comfortable homelike setting. This deficient practice was identified for 3 of 3 units, and was evidenced by the following: 1. On 2/5/25 at 9:00 AM, the surveyor entered the facility and observed the lobby floor to be dirty with scuff marks and discolored tiles. The elevator floors were also observed to be dirty and discolored and the walls of elevators were observed to be soiled. On 2/5/25 at 9:15 AM, during initial tour of the	F 584	1. "The US FOIA (b)(6) was in serviced on the facility policies on keeping resident areas clean and presentable. " Room NJ Exec Ord has been cleaned and is free of soiled/sticky floors. " Room NJ Exec D furniture has been replaced. Room NJ Exec D bedside table has been replaced " All resident rooms will have a full maintenance and housekeeping audit done monthly x 3 months to ensure all aspects of the room are functioning properly. " All the Unit Managers and the	

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F 584	Continued From page 6 Third-floor nursing unit, the surveyor observed the following environmental issues: In Resident Room [NJ Exec Order 26], the floor was observed to be soiled and sticky with liquid spills on the floor. The unsampled resident's trash was overflowing and there was trash on the floor under the bed. In Resident Room [NJ Exec Order 26.4b1] the surveyor observed that the resident's clothes drawers were broken; peeling [NJ Exec Order 26.4b] on the dresser; no drawer front on the bedside table; drawers were broken and hanging awkwardly and could not be closed. The floor was stained dirty with brown substance behind A bed; molding and baseboard off the wall were lying on the side of the resident's bed in bed B. The surveyor lifted the board and underneath the boards on the floor was very dirty and dusty with used straws and silver money on the floor. The ceiling bed curtain track was broken and hanging from ceiling with no middle privacy partition curtain and two ceiling tiles hanging and buckling. The surveyor observed in Resident Room #[NJ Exec O] the bedside table was broken. On 2/5/25 at 9:15 AM, the surveyor interviewed the [US FOIA (b)(6)], who stated that maintenance and housekeeping concerns were verbally told to the perspective departments when issues were noted in residents' rooms. The [US FOIA] stated that she was aware about the concerns related to housekeeping and maintenance issues in Resident Room #[NJ Exec O] #[NJ Exec O] and #[NJ Exec O] however she did not fill out the concerns in the computer system to notify the housekeeping or maintenance regarding these issues.	F 584	housekeeping team were in serviced on the carbolization protocol. " All department heads were inserviced on how to use TELS. " The first floor shower room will be checked and cleaned daily. " The first floor shower curtain has been replaced. 2. " All residents have the potential to be affected by this deficient practice. 3." All department heads were in-serviced on how to use [NJ Exec Order 2] " Audits for the deficient areas put into place. " In servicing for all department heads. 4. All resident rooms will be audited monthly by the Housekeeping and Maintenance Directors and the results of audits completed will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 584	Continued From page 7 On 2/5/25 at 9:30 AM, the surveyor attempted to interview the housekeeping staff on the Third-floor nursing unit, and they indicated that NJ Exec Order 26.4b1 [redacted]. On 2/5/25 at 9:45 AM, the surveyor interviewed the US FOIA (b)(6) [redacted]), who stated that no one reported the maintenance concerns or the condition of the resident's furniture in rooms NJ Exec O [redacted] or NJ Exec O [redacted] The US FOIA [redacted] stated that maintenance issues were reported into the computer system. The US FOIA [redacted] accompanied the surveyor to Resident Room # NJ Exec O [redacted] and he stated that he had not received any work orders or reports regarding the condition of that room. On 2/5/25 at 9: 50 AM, the surveyor interviewed the US FOIA (b)(6) [redacted], who accompanied the surveyor to Resident Room # NJ Exec O [redacted] and Resident Room # NJ Exec O [redacted] to observe the uncleanliness of the unsampled resident's rooms. The US FOIA [redacted] stated that he did the best he could with the staff he had to work with. The US FOIA [redacted] stated that the floors were cleaned daily and maybe the housekeeper did not get to those rooms yet. The US FOIA [redacted] then directed the housekeepers to clean the floors in the residents' rooms. The US FOIA [redacted] stated that all rooms were carbolized once a month, however staff kept taking the signs down. The US FOIA [redacted] did not have an explanation why the floors were not clean. On 2/13/25 at 10:02 AM, the surveyor interviewed the US FOIA (b)(6) [redacted] who stated that if the staff saw that the floors were dirty or needed cleaning, the staff should be notifying the housekeeping department to clean those rooms first. The US FOIA (b)(6) stated	F 584		

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that if there was broken furniture or broken items in a resident's room, that the staff should be reporting it to maintenance through the computer system that produced maintenance work orders. The [US FOIA (b)(6)] explained that if the maintenance or housekeeping department did not respond timely to concerns, then she would verbally remind them. The [US FOIA (b)(6)] stated that she had told the administration about the poor condition of the dining room chair and the administration did buy new chairs. The [US FOIA (b)(6)] stated that the condition of Resident Room #[NJ Exec] was "embarrassing" and the room should not have been in that condition.

On 2/13/25 at 10:18 AM, the surveyor interviewed the [US FOIA (b)(6)], who stated that she was aware that the furniture in the resident's rooms were not in good condition. The [US FOIA (b)] bought the surveyor to Resident Room #[NJ Exec] and showed the surveyor the molding on the resident's wall behind bed B, which was broken, missing pieces and in disrepair. The [US FOIA (b)] also went room to room and showed the surveyor the dirt that was underneath the multiple resident's dressers and stated that she did not know why the housekeepers did not pull the furniture out to clean under the dressers. The [US FOIA (b)] stated that the [US FOIA] was aware of the issues and that he was notified of the concerns regarding the cleanliness of the floors. She also stated that when there was a maintenance issue, the staff filled out the work form on the computer system, but the concerns did not always get fixed.

On 2/13/25 at 12:28 PM, the surveyor interviewed the [US FOIA (b)(6)], who stated that the facility's work order computer system instructed him to perform 20 weekly tasks. The [US FOIA] stated that maintenance rounds were driven

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F 584	Continued From page 9 by the computer system and environmental rounds were conducted in August 2024, with US FOIA (b)(6)). The US FOIA stated that during those rounds, the US FOIA (b)(6) and himself generated a list of maintenance issues which were completed a week later for each floor. The US FOIA stated that the US FOIA (b)(6) and himself were aware that the furniture in the resident's room needed to be replaced and he had brought it up in Quality Assurance and Performance Improvement (QAPI) meeting. The US FOIA stated that after maintenance received a work order, he would have expected it to be completed within 24 hours. The surveyor showed the US FOIA pictures of the condition of Resident Room # NJ Exec O and he confirmed that it was unacceptable. On 2/14/25 at 10:58 AM, the surveyor interviewed the US FOIA (b)(6)), who stated that the environment was "awful" and the US FOIA (b)(6) stated that he had conversations with corporate regarding getting new furniture, however, could not provide additional information regarding the purchasing of new furniture to the surveyor. 2. On 2/5/25 at 11:06 AM, the surveyor observed the Second-floor nursing unit and identified the following concerns: In Resident Room # NJ Exec Order 26.4b1 the base board detached from the wall behind the bed frame. The nightstand located near the resident's bed had the bottom door hanging awkwardly which could not be properly closed and the NJ Exec Order 26.4b (laminated plastic used to make cabinets) was peeling off the bottom of the nightstand.	F 584		

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On 2/13/25 at 9:54 AM, the surveyor interviewed the [US FOIA (b)(6)]), who stated that when there was an environmental problem or broken items in a resident's room, we reported it to the maintenance department. The [US FOIA (b)(6)] further stated that they used a computer system to report things to maintenance. The [US FOIA (b)(6)] acknowledged that the baseboards should not be detached from the wall and that the nightstands should not have the doors hanging off.

On 2/13/25 at 12:27 PM, the surveyor interviewed the [US FOIA] in the presence of the survey team, who stated that the facility used a computer program where staff entered a concern for the maintenance department. The [US FOIA] stated that the computer system instructed him to perform 20 weekly tasks. The [US FOIA] stated that maintenance rounds were driven by the computer system and environmental rounds were conducted in August 2024, with the [US FOIA (b)(6)] He stated that during those rounds, the [US FOIA (b)(6)] and himself generated a list of maintenance issues which were completed a week later for each floor. The [US FOIA] further stated the resident's rooms should be kept clean, well kept, and have a homelike environment. The [US FOIA] stated that the [US FOIA (b)(6)] and himself were aware that the furniture in the resident's rooms needed to be replaced and he had brought it up in the QAPI meeting. The [US FOIA] stated that after the maintenance received a work order, he would have expected it to be completed within 24 hours. The surveyor showed the [US FOIA] pictures regarding the condition of Resident Room #[NJ Exec O] and he stated that it was unacceptable.

On 2/14/25 at 10:59 AM, the [US FOIA (b)(6)] in the presence of the [US FOIA (b)(6)] and the survey team,

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stated that the environment was "awful" and the [US FOIA (b)(6)] stated that he had conversations with corporate regarding getting new furniture. The [US FOIA (b)(6)] acknowledged the surveyor's environmental concerns.

3. On 2/5/25 at 11:05 AM, during initial tour of the facility, the surveyor observed Resident #[NJ Exec] in their room resting in bed. Next to the bed was a nightstand which appeared to be in disrepair. The nightstand was missing the drawer with the resident's personal belongings that were set on the shelf where there would have been a drawer. The resident was unable to verbalize to the surveyor how they felt about the condition of their furniture.

On 2/13/25 at 11:44 AM, during dining observation, the surveyor observed the main dining room on the Third-floor nursing unit to have damaged walls with the wallpaper peeling up and away from the wall starting from the baseboard trim. There were also holes in the wall with drywall showing and areas patched with mismatched materials.

On 2/13/25 at 11:47 AM, the surveyor interviewed the [US FOIA (b)(6)] who stated that she was not sure how long the wall had been in that condition; that it had been that way since she was hired at the facility [NJ Exec Order 26.4b1].

On 2/13/25 at 12:28 PM, the surveyor interviewed the [US FOIA (b)] who stated that the facility work order computer system instructed him to perform 20 tasks weekly. The [US FOIA] stated that maintenance rounds were driven by the computer system and environmental rounds were conducted in August

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SHORE GARDENS REHABILITATION AND NURSING CENTER	**231 WARNER STREET TOMS RIVER, NJ 08755**

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2024, with the [redacted]. The [redacted] stated that during those rounds, the [redacted] and himself generated a list of maintenance issues which were completed a week later for each floor. The [redacted] stated that the [redacted] and himself were aware that the furniture in the resident's room needed to be replaced new and he had brought it up in the QAPI meeting. The [redacted] stated that after the maintenance received a work order, he would have expected it to be completed within 24 hours.

On 2/14/25 at 10:58 AM, the surveyor interviewed the [redacted] who stated that the environment was "awful" and the [redacted] stated that he had conversations with corporate regarding getting new furniture, however, could not provide additional information regarding the purchasing of new furniture to the surveyor.

4. On 2/5/25 at 12:04 PM, the surveyor observed a coded door lock that had push buttons falling out to get into the First-floor shower room. The surveyor entered the shower room and observed: dirty tile floors; a rusted metal rack holding a used blue/green bar of soap; blue flower grip stickers that were discolored black on the floor of the shower; a broken shower hook to hold the handheld shower nozzle that had sharp jagged edges; a broken patched soap holder in the shower wall that was rough to the touch and a shower curtain that had brown and orange discoloration throughout on the interior shower side, it also revealed brown discoloration stripes in the middle of the curtain.

On 2/12/25 at 12:13 PM, the surveyor interviewed with [redacted] who stated that he had a monthly schedule in place to change the communal

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resident's shower curtain. The [US FOIA] could not provide an accountability log and could not determine when the last time the shower curtain was changed. He further stated that the shower rooms were cleaned daily by staff.

On 2/12/25 at 10:47 AM, the surveyor interviewed the [US FOIA] who stated that he made rounds throughout the facility regularly and inspected the residents' rooms and shower rooms. If there was a maintenance issue or something was broken, all staff had access to the electronic maintenance system. The [US FOIA] stated that the system provided the maintenance department with a work order if something needed to be fixed. The shower room was not on the electronic maintenance system.

On 2/12/25 at 12:41 PM, the surveyor interviewed the First-floor nursing unit's [US FOIA (b)(6)], who stated that staff used the electronic maintenance system sometimes, sometimes they told the maintenance staff verbally in the hallway or they wrote the concern in a maintenance log. The surveyor observed the maintenance log and Shower Room C1-17 was not listed.

On 2/12/25 at 12:47 PM, the surveyor accompanied by the [US FOIA (b)(6)] toured Shower Room C1-17. [US FOIA (b)(6)] stated that the shower room was not clean, and "did not have a homelike feel. I would not shower in here."

On 2/13/25 at 12:27 PM, the surveyor conducted a follow-up interview with the [US FOIA] who stated that the maintenance log system should not be used; that the electronic maintenance system was used for notification. The [US FOIA] stated if staff approached him in the hallway to fix something, he directed them to add a work order in the electronic

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F 584	Continued From page 14 system. On 2/14/25 at 10:58 AM, the survey team met with the US FOIA (b)(6), who both acknowledged the surveyor's concerns. They were unable to provide additional information. A review of the facility's undated "Director of Maintenance job description" indicated that the purpose of the position was to maintain the orderly functioning of all equipment in the facility to include the kitchen; laundry; heating; air conditioning and elevators as well as purchasing necessary supplies for repairs, maintenance, and emergencies within budgetary. A review of the facility's undated "Director of Housekeeping job description" reflected that the HD was responsible for planning, directing, coordinating, reporting, budgeting, and physical management of the housekeeping departments employees and equipment in a way that maximum cleanliness and order throughout the building and laundry services for both resident clothing and facility linen. A review of the facility's undated "Cleaning and Disinfection of Environmental Surfaces" policy included that environmental surfaces would be cleaned and disinfected according to the current Center for Disease Control (CDC) recommendations for disinfection of healthcare facilities and Occupational Health and safety Administration (OSHA) bloodborne pathogens standard... A review of the facility's undated "Quality of life-Homelike Environment" policy included residents would be provided with a safe, clean	F 584		

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F 584	Continued From page 15 and comfortable homelike environment...facility staff and management shall maximize to the extent possible, the characteristics of the facility to reflect a personalized homelike setting. These characteristics include: Clean and sanitary and orderly environment and inviting color and décor...	F 584		
F 658 SS=D	NJAC 8:39-31.4(a) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the medication cart was secured during medication administration in accordance with professional standards of clinical practice. This deficient practice was identified for 1 of 4 residents observed during medication administration (Resident #89), and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching	F 658	1.• On 3/4/2025 DON/ADON met with RN's and LPN'S to provide an in-service regarding accepted standards of clinical practice specific to Medication administration and Shore Gardens Medication Administration Policy in which it states. When the medication cart is not in the direct line of sight of the nurse it must always remain closed and locked. 2. • All Residents have the potential to be affected by this deficiency 3.• Pharmacy Consultant will provide monthly Medication Administration Audits and submit to the DON/ADON paying specific attention to medication cart safety and the locking of the cart when out of	3/11/25

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F 658	Continued From page 16 program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 2/10/25 at 8:17 AM, the surveyor observed the US FOIA (b)(6)) parked the Second-floor low-side medication cart outside the door of Resident #89's room. The US FOIA (b) sanitized their hands with an alcohol-based hand rub, and she prepared the medications to be administered to Resident #89. After gathering a cup containing NJ Exec O medications and NJ Exec Order 26.4b1, the US FOIA (b) left the medication cart unlocked and walked to Resident #89's bedside. The US FOIA (b) proceeded to administer the resident their medication who was in bed. The medication cart was out of the line of sight of the US FOIA (b) and no residents were observed present in the hallway and by the medication cart. The surveyor asked the US FOIA (b) what they would do with the cart, and the US FOIA (b) confirmed that they should have locked it. On 2/12/25 at 12:15 PM, the surveyor interviewed the US FOIA (b)(6) , who stated that during medication administration, the nurses should always lock the cart and minimize the computer when walking away from the medication cart. During an interview with the survey team on 2/13/25 at 1:25 PM, the surveyor brought the identified concern to the attention of the US FOIA (b)(6) They did not dispute the findings. A review of the facility provided undated	F 658	direct line of sight. • Unit Managers/Nursing Supervisors will round each shift using given audit form to ensure standards of clinical practice are being met and report findings to DON/ADON 4.• Medication Administration pass audits will be reviewed upon completion by DON/ADON • DON/Designee will report monthly findings to the Quality Assurance Performance and Implementation committee x 3 months • A decision will be made to continue such audits by the Quality Assurance Performance and Implementation team if necessary.	

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F 658	Continued From page 17 "Administering Medications" policy included Policy Interpretation and Implementation 18. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide...	F 658		
F 695 SS=D	NJAC 8:39-29.4(h) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to a) obtain physician's orders for care of NJ Exec Order 26.4b1 and b) develop a comprehensive care plan for a resident receiving NJ Exec Order 26.4b1. This deficient practice was identified in 1 of 4 residents reviewed for [redacted] (Resident #95), and was evidenced by the following: On 2/5/25 at 12:07 PM, during the initial tour of the facility, the surveyor observed an [redacted] in Resident #95's room with NJ Exec Order 26.4b1 [redacted] connected. The [redacted] went from the	F 695	• On 2/5/2025 a Physicians order was received written as the following: Change NJ Exec Order 26.4b1 weekly for Resident #95 • On 2/5/2025 a Care Plan specific to [redacted] use was implemented for Resident #95 • On 3/4/25 RN's and LPNs were provided in-servicing regarding Shore Gardens Respiratory Equipment policy, specific to the changing of NJ Exec Order 26.4b1 on a weekly basis after retrieval of a Physicians order. • On 3/4/25 RN's and LPNs were provided in-servicing regarding Shore Gardens Respiratory Equipment policy, specific to the implementation of Comprehensive/Basic care planning.	3/11/25

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F 695	Continued From page 18 NJ Exec Order 26.4b1 onto the resident's bed, under the pillow, and hung off the opposite side of the bed. At that time, the resident informed the surveyor that they removed the NJ Exec Order 26.4b A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with medical diagnoses that included but were not limited to; NJ Exec Order 26.4b1 [redacted]. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b, revealed Resident #95 had a Brief Interview of Mental Status score of NJ Exec out of 15, meaning the resident had NJ Exec Order 26.4b1. A review of Section NJ E titled 'NJ Exec Order 26.4b1 [redacted] indicated that the resident used NJ Exec Order 26 prior to admission and at the facility. A review of the Physician Order Summary revealed that Resident #95 was prescribed NJ Exec Order 26 to be administered at NJ Exec Order 26.4b1 [redacted] as needed. The order was dated NJ Exec Order 2, and was an active order. The Physician Order Summary did not include a physician's order to change the NJ Exec Order 26.4b1 [redacted] On 2/13/25 at 11:10 AM, the surveyor went to see Resident #95 and observed the room was empty. The surveyor went to the First-floor US FOIA (b)(6) [redacted]), who stated that the resident went to the hospital in the morning for NJ Exec Order 26.4b1. The surveyor then asked	F 695	• An Audit was done on 3/3/25 by the ADON of all residents who require the use of oxygen/respiratory equipment to ensure the placement of a physicians order. • An Audit was done on 3/3/25 by the ADON of all residents who require the use of oxygen/respiratory equipment to ensure a Comprehensive Care Plan has been implemented specific to oxygen use. • All Residents have the potential to be affected by this deficiency • On 3/4/25 Unit Managers/Nursing Supervisors were in-serviced regarding the review of new admissions and re-admissions and the implementation of the Basic and Comprehensive Care Plan (Specific to the use of Oxygen but not limited to) as well as Shore Gardens Respiratory Equipment Policy. • On 3/4/25 RN's and LPN's were in-serviced regarding Oxygen/Respiratory equipment Physician orders and standards of practice. The Physicians' order must also contain a weekly change of tubing. • New/Re-admissions will have a thorough medical record review by the clinical team no later than 72 hours post admit ensuring implementation of Care plans • The DON/ADON will do a monthly audit x 3 months and report findings to the Quality Assurance Performance and Implementation team.	

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F 695	Continued From page 19 the US FOIA (b)(6) to show them the physician's orders for NJ Exec Order 26 and NJ Exec Order 26.4b1 in the Electronic Medical Record (EMR). The US FOIA (b)(6) showed the surveyor an order for NJ Exec Order 26 to be administered at NJ Exec Order 26.4b1 as needed. The surveyor then asked about the NJ Exec Orde and the US FOIA (b)(6) said, "Usually there would be order here." The surveyor asked where the NJ Exec Order 26.4b1 would be signed out and she said, "In the EMR but it looks like it's not being signed out." On 2/13/25 at 11:53 AM, the surveyor reviewed the policy titled "Oxygen Administration" with a revision date of 2010. The policy purpose was to provide guidelines for NJ Exec Order 26.4b1 administration. The policy did not include the care of NJ Exec Order 26 On 2/13/25 at 11:59 AM, the surveyor reviewed the resident's comprehensive care plan. The care plan did not have a focus area for NJ Exec Order 26.4b1 care or NJ Exec Order 26.4 On 2/14/25 at 10:58 AM, the surveyor asked the US FOIA (b)(6) if a resident with NJ Exec Order 26 should have an NJ Exec Order 26 or NJ Exec Order 26.4b1 care plan, and the US FOIA (b) acknowledged by stating, "NJ Exec O any resident should have a care plan if they have NJ Exec Order 26.4b1	F 695	• A decision will be made to continue the audits by the Quality Assurance Performance and Implementation team if necessary.	
F 755 SS=D	NJAC 8:39-25.2 (b) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		3/11/25

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F 755	Continued From page 20 them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and pertinent record review, it was determined that the facility failed to ensure the accountability of the narcotic shift count logs were completed in accordance with professional standards of practice. This deficient practice was identified on 2 of 3 medication carts, and was evidenced by the following:	F 755	• On 2/11/25 an Audit was done on all units for accountability of Narcotic logs. • On 3/4/25 RN's and LPN's were in-serviced by the DON/ADON specific to counting Narcotics and the Medication Administration Policy of Shore Gardens stating the following: Narcotics are to be counted by TWO licensed nurses at the start of your shift and the end of your shift	

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F 755	Continued From page 21 On 2/10/25 at 11:11 AM, the surveyor, in the presence of the Licensed Practical Nurse (LPN #1), observed the Third-floor high side nursing unit's medication cart. A review of the medication cart's narcotic logbook revealed a pre-signed outgoing nurse signature for the shift-to-shift narcotic count "Narcotic Bingo Card Count Sheet" for the 2/10/25 3:00 PM- 11:00 PM shift. At that time, LPN #1 confirmed that she had pre-signed the log and that the log should have been signed in the presence of the incoming nurse by both herself and the incoming nurse at the same time after a narcotic count was completed. On 2/10/25 at 11:41 AM, the surveyor, in the presence of LPN #2, observed the Second-floor low side nursing unit's medication cart. A review of the medication cart's January 2025's shift-to-shift log revealed missing nurses' signatures for the narcotic counts for the following shifts: On 1/1/25, the outgoing nurse for the 7:00 AM - 3:00 PM (day shift). On 1/4/25, the incoming nurse for the 3:00 PM - 11:00 PM (evening shift). On 1/4/25, the incoming and outgoing nurses for the 11:00 PM - 7:00 AM (night shift). On 1/5/25, the incoming and outgoing nurses for the day shift. On 1/5/25, the outgoing nurse for the evening shift. On 1/8/25, the incoming nurse for the day shift. On 1/8/25, the outgoing nurse for the evening shift. On 1/9/25, the incoming and outgoing nurses for the evening shift. On 1/9/25, the outgoing nurse for the evening shift and night shifts.	F 755	in order to reconcile a detailed receipt and disposition of all controlled substances/Narcotics • All Residents have the potential to be affected by this deficiency • Unit Managers/Supervising Nurses will audit Narcotic/Controlled substance decline logs daily and report findings to DON. • DON will audit Narcotic/Controlled Substance logs monthly x 3 months • DON/Designee will report monthly findings to the Quality Assurance Performance and Implementation committee x 3 months • A decision will be made to continue such audits by the Quality Assurance Performance and Implementation team if necessary.	

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F 755	Continued From page 22 On 1/10/25, the incoming nurse for the day and night shifts. On 1/10/25, the outgoing nurse for the evening shift. On 1/11/25, the outgoing nurse for the day shift. On 1/11/25, the incoming nurse for the night shift. On 1/12/25, the outgoing nurse for the day shift. On 1/13/25, the incoming nurse for the day shift. On 1/13/25, the outgoing nurse for the evening shift. On 1/27/25, the incoming nurse for the day shift. On 1/27/25, the outgoing nurse for the evening shift. On 1/31/25, outgoing nurse for the evening shift. At that time, LPN #2 confirmed that there should not have been any missing signatures or documentation on the narcotic count log sheet. LPN #2 confirmed that the incoming and outgoing nurses were supposed to count the narcotics together and sign the log together at the time of shift change to confirm the count was completed and accurate. On 2/13/25 at 12:39 PM, the surveyor interviewed the US FOIA (b)(6) [redacted]). Both the US FOIA (b)(6) stated that medication cart narcotics were to be counted and immediately signed by the incoming and outgoing nurses at the time of shift change to indicate the count was completed. The US FOIA (b)(6) [redacted] stated that there should not have been any pre-signed spaces or blanks for previous shifts. The US FOIA (b) [redacted] acknowledged that missing documentation indicated it was not done. A review of the facility's "Controlled Substance" policy with a revised date of November 2022, included the system of reconciling the receipt,	F 755		

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F 755	Continued From page 23 dispensing and disposition of controlled substances includes the following:... nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services... NJAC 8:39-29.7(c)	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		3/11/25

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F 761	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a) label opened multidose medication; b) properly dispose of expired medications; and c) properly store medical supplies. This deficient practice was observed on 2 of 3 medication carts and 1 of 2 medication storage rooms reviewed for medication storage and labeling, and was evidenced by the following: On 2/10/25 at 11:11 AM, the surveyor, in the presence of the Licensed Practical Nurse (LPN #1), observed the following on the Third-floor high side nursing unit's medication cart: Fourteen individual, single use vials of ipratropium bromide/albuterol sulfate inhalation solution (a medication used to treat lung disease) 0.5 milligrams (mg) /3 mg per 3 milliliter (ml) in an opened foil pouch with a hand-written opened date of 1/2/24. The medication's foil pouch had manufacturer's instructions printed on it which indicated that the medication was to be used within two weeks of the pouch being opened. At that time, LPN #1 acknowledged the opened date and confirmed that the medication was considered expired and needed to be discarded. On 2/10/25 at 11:41 AM, the surveyor, in the presence of LPN #2, observed the following on the Second-floor low side nursing unit's medication cart: Two boxes of ipratropium bromide/albuterol sulfate 0.5 mg /3 mg per 3 ml inhalation solution. One box contained an opened foil pouch dated	F 761	• LPN #1 and LPN #2 were in serviced regarding the labeling and storing of drugs and biologicals specifically Medications with shortened expiration dates after opening. • On 2/10/2025 an audit was performed by the DON/ ADON on all unit Medication Carts and in Medication Storage rooms for expired medications. • On 2/10/2025 an audit was performed by the DON/ADON on all unit Medication Storage rooms to ensure that drugs and biologicals are in locked compartments under temperature controls. • On 2/10/2025 an audit was performed by the DON/ADON ensuring that any Respiratory/Medical Equipment stored within Medication storage rooms are wrapped in plastic and kept in a clean, sanitary manner. • US FOIA (b)(6) In-serviced regarding the storage of all drugs and biologicals in locked compartments under temperature controls and permit only authorized personnel to have access to the keys. • The cabinet under the sink on the second floor, in the medication storage room was emptied, disinfected and closed by the MD with permanent fixation. • On 3/4/25 All RN's and LPN's were in-serviced regarding the Shore Gardens Medication labeling and storage policy as well as the Respiratory/Medical Euipment Storage policy. • All Residents have the potential to be affected by this deficiency	

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F 761	Continued From page 25 "12/7" containing 15 individual single use vials, and the second box contained an opened and undated foil pouch containing 25 individual, single use vials. Both were labeled with the manufacturer's instructions to use within two weeks of opening. At that time, LPN #2 confirmed that multidose medications should be dated with the date it was opened to keep track of the shortened expiration date once opened and confirmed that those medications should have been considered expired. On 2/10/25 at 12:06 PM, the surveyor in the presence of the US FOIA (b)(6)), observed the following in the Second-floor medication storage room: In the cabinet under the storage room's sink was stored the following: Sixty abdominal pad sterile dressings in a plastic bag. Four feeding tube irrigation sets in a plastic bag. Thirteen sterile rolled gauze bandages in a plastic bag. Three nebulizer machines (medical equipment used for respiratory treatments) which were not in plastic bags. Upon moving those items, the surveyor observed a reddish-brown substance covering the base of the cabinet that those items were stored on top. At that time, the US FOIA (b)(6) confirmed that the cabinet under the sink would not be considered a clean and acceptable storage area for medical supplies and would be considered an infection control risk. Further observation in the medication storage	F 761	• 11-7 Nurse will audit unit Medication Carts and Medication Storage rooms for expired medications daily and report findings to DON x 3 months • 11-7 Nurse will audit unit Medication Carts and Medication Storage rooms for Medical equipment and the proper storage of, daily x 3 months • 11-7 Nurse will report daily findings to DON/Designee • DON/Designee will report findings to the Quality Assurance Performance and Implementation committee x 3 months • A decision will be made to continue such audits by the Quality Assurance Performance and Implementation team if necessary.	

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F 761	Continued From page 26 room revealed: One 1000 ml bag of intravenous (IV) 0.9% normal saline solution (NSS) expired December 2024. One 1000 ml bag of IV 5% dextrose/0.9% NSS expired May 2024. On 2/13/25 at 12:39 PM, the surveyor interviewed the US FOIA (b)(6)), who both acknowledged that the multidose medications should have been labeled and dated with the date it was opened to properly keep track of the expiration dates. They both acknowledged that medications should have been discarded from storage when they reached their expiration date. The US FOIA (b)(6) also confirmed that medical supplies and medications should "never" be stored in a cabinet under the sink because it was considered an infection control issue. The US FOIA (b) acknowledged that storing nebulizer machines under the sink could allow for growth of unwanted organisms and could potentially cause "serious respiratory problems." A review of the facility's "Medication Labeling and Storage" policy with a revised date of February 2023, included...the facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls...the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items ...multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within	F 761		

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F 761	Continued From page 27 28 days unless the manufacturer specifies a shorter or longer date for the open vial... A review of the facility's undated "Departmental (Respiratory Therapy) prevention of infection" policy did not include proper storage of oxygen therapy equipment when not in use.	F 761		
F 812 SS=F	NJAC 8:39-29.4(a)(h) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness and b.) maintain kitchen equipment in a clean and sanitary manner	F 812	" The US FOIA (b)(6) was in serviced on the importance of sealing bags and labeling the sealed bags with used by dates. " The US FOIA (b)(6) was in	3/11/25

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F 812	Continued From page 28 as evidenced by the following: On 2/5/25 at 9:26 AM, in the presence of the US FOIA (b)(6)), the surveyor observed the following: 1. In the walk-in freezer, one opened box of raviolis and one opened box of chicken breasts in the manufacturer's box. Both products were in bags that were not sealed closed exposing the contents to air with ice crystals. Neither products were labeled with an opened or use by dates. The US FOIA (b) was unable to say when the packages were opened. 2. The steam table with one main water well and six pan capacity had white murky water with sediment of food particles on the bottom and green food particles floating on the top of the water. The US FOIA (b) stated the steam table water was drained and changed daily at the end of the day, and she acknowledged that it had not been done yet. The US FOIA (b) could not provide work accountability logs and was unaware of the last time it was changed. 3. Four plastic colored cutting boards were deeply pitted and discolored white from use. On 2/5/25 at 10:28 AM, the surveyor interviewed the US FOIA (b) who acknowledged that the freezer items should have been labeled with an opened date and if only part of the bag was used, it should be resealed and labeled. The US FOIA (b) acknowledged that the cooking equipment should have been cleaned and maintained in a sanitized way to prevent food borne illness and contamination.	F 812	serviced on the importance of keeping the steam table clean and retaining logs of daily cleaning. " New cutting boards were ordered immediately. " All residents have the potential to be affected by this deficient practice. The US FOIA (b)(6) was inserviced on the importance of sealing bags and labeling the sealed bags with used by dates. All kitchen logs will be will be audited by the Dietary Dirctor monthly x 3 months and the results of audits completed will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 812	Continued From page 29 On 2/14/25 at 10:58 AM, the survey team met with the US FOIA (b)(6) [redacted]), who both acknowledged the surveyor's concerns. No additional information was provided. A review of the facility's undated "Sanitation Policy" included food service areas shall be maintained in a clean and sanitary manner ...for fixed equipment that does not fit in the dishwasher machine, equipment should be disassembled to allow detergent solution of all parts... A review of the facilities "Refrigeration and Freezers" policy dated revised November 2022, included all food is appropriately dated to ensure proper rotation ... Expiration dates on all unopened food and "use by" dates are indicated when food is opened ... A review of the facility's undated "Sanitation Policy" included food service employees shall prepare and serve in a manner that complies with safe food handling practices ... food preparation staff will adhere to proper hygiene and sanitary practices to prevent food borne illness ...	F 812		
F 814 SS=D	NJAC 8:39-17.2(g) Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 814		3/11/25

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F 814	Continued From page 30 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to dispose of garbage and refuse properly to prevent rodents and pests. This deficient practice was evidenced by the following: On 2/5/25 at 9:32 AM, the surveyor toured the facility grounds and loading dock area with the US FOIA (b)(6)). The surveyor observed the following. 1. The grassy side yard, which the First-floor residents looked at from their windows, was filled with construction debris, pallets that were broken and thrown around, plastic wrap in the trees, Styrofoam panels, and paper litter in the tree line that ran along neighborhood fences. 2. Along the black top driveway and grassy area, there were cigarette butts (too numerous to count) thrown on the ground. There was a cigarette receptacle lying on its side in the grass. 3. Behind a short brick wall, there were construction debris, metal benches, milk cartons, and tarps thrown haphazardly. 4. Behind a large blue storage trailer shed, there were orange milk crates thrown, construction trash, soda cans, and gloves on the ground. 5. The facility had three green trash dumpsters, around the dumpsters on the ground were gloves, soda cans, and cigarette butts. On 2/11/25 at 9:42 AM, the surveyor and the	F 814	" The grounds have been cleaned up. " The US FOIA (b)(6) has been inserviced on his responsibility of keeping the grounds clean. " All residents have the potential to be affected by this deficient practice. The grounds will be cleaned and checked weekly to maintain a property free of litter. The weekly ground checks will be audited by the maintenance director monthly and the results of audits completed will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 814	Continued From page 31 US FOIA (b)(6)) went to observe the surveyor's findings. The US FOIA (b)(6) acknowledged the concern and stated, "it should not be like this." The US FOIA (b)(6) stated it was "not fair" the residents to had to look at it and the trash could lead to a rodent and pest problem. On 2/13/25 at 12:27 PM, the surveyor interviewed the US FOIA (b)(6) , who stated that he was unaware that he was responsible for the grounds maintenance, and he was just given the policy yesterday. On 2/13/25 at 1:07 PM, the surveyor interviewed the US FOIA (b)(6) who stated that he was unaware he was responsible for the grounds maintenance. The US FOIA stated he was just given the policy yesterday and was asked to clean it up. The US FOIA stated he started cleaning up the area from trash and debris. The US FOIA further stated that he was "actually" "a little afraid of what might pop out of the ground" when he was cleaning behind the wall. On 2/14/25 at 10:58 AM, the survey team met with the US FOIA (b)(6)), who both acknowledged the surveyor's concerns. A review of the facility's undated "Grounds" policy included ...facility grounds shall be maintained in a safe and attractive manner ...maintenance shall be responsible for keeping the grounds free of liter... A review of the facility's undated "Food-related Garbage and Refuse disposal," policy included storage areas will be kept clear at all times and shall not constitute a nuisance ...outside dumpsters will be kept free from surrounding liter	F 814		

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F 814	Continued From page 32 ... A review of the facility's undated "Smoking Policy," included the facility will ensure compliance with [New Jersey Department of Health] smoking guidelines.	F 814		
F 880 SS=D	NJAC 8:39-31.4(a) 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 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 §483.71 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:	F 880		3/11/25

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F 880	Continued From page 33 (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 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:	F 880		

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F 880	Continued From page 34 Based on observation, interview, and review of facility policies, it was determined that the facility failed to use appropriate infection control practices during medication administration to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines and standards of clinical practice. This deficient practice was identified for 1 of 4 residents observed during medication administration (Resident #96), and was evidenced by the following: Reference: Hand hygiene should be performed immediately before touching a patient; before performing an aseptic task such as placing an indwelling device or handling invasive medical devices; before moving from work on a soiled body site to a clean body site on the same patient; after touching a patient or patient's surroundings; after contact with blood, body fluids, or contaminated surfaces; immediately after glove removal. CDC recommendations for Hand Hygiene: Updated February 27, 2024: https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html#cdc_clinical_safety_best_practices_recomm-recommendations On 2/10/25 at 8:17 AM, the surveyor observed the Licensed Practical Nurse (LPN #1) prepare medications to administer to Resident #96. LPN #1 sanitized her hands with alcohol-based hand rub and proceeded to remove medication tablets from three blister packs and one medication bottle. LPN #1 then prepared the inhaler device for the resident to use. Without performing hand hygiene and donning (wearing) clean gloves, LPN #1 was observed using their bare left forefinger and thumb to push one tablet of NJ Exec Order 26.4b1	F 880	LPN #1 prepared medication for resident #96 without proper hand hygiene. Resident #96 was since provided medication with proper hand hygiene. LPN #1 was in-serviced on hand hygiene and donning gloves prior to conducting medication administration and patient care. " All residents have the potential to be affected by this deficient practice. LPN #1 has been in serviced on the facility□s Hand hygiene policy. The results of the monthly audits completed will be performed by the ADON and submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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 02/14/2025

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 35	F 880		

NJ Exec Order 26.4b1) into the medicine cup. The surveyor asked LPN #1 if the observed process for obtaining a medication from a bottle was correct and what would they do with a tablet they touched with their bare fingers? LPN #1 acknowledged that they should not have touched the tablets and that they had to discard the contaminated tablet.

On 2/12/25 at 12:13 PM, the surveyor asked LPN #2 what the process was to obtain medications from a bottle, and LPN #2 stated that they had to tap the bottle to move the tablets to the cap or wear gloves to get the medication from the bottle if tapping was not successful. LPN #2 also stated that they needed to sanitize or wash hands after removing gloves.

On 2/12/25 at 12:15 PM, the surveyor asked the US FOIA (b)(6) what the process was to obtain medications from a bottle, and the US FOIA (b)(6) stated that they needed to wear gloves and sanitize their hands before and after discarding the gloves.

During an interview with the survey team on 2/13/25 at 1:25 PM, the US FOIA (b)(6) were notified of the above findings and concerns.

A review of the facility provided undated "Handwashing/Hand Hygiene" policy included under Policy Interpretation and Implementation...6. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub...Statement:..d. Before and after handling medications...

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 02/14/2025

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 36 NJAC 8:39-19.4(a)1	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	656002	A. BUILDING: _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NUR	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) COMPLETE DATE
S 000	Initial Comments Complaint #: NJ 182524, 182687 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 182524, 182687 Based on interview and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 18 out of 84 shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	" Staffing coordinator was educated on New Jersey state staffing ratio requirements " Efforts to hire facility staff will continue until there is adequate staff to meet the minimum staff to resident ratios. Until that time, the facility will use staffing agencies and offer additional shifts to current staff with bonuses as required. " Facility Administrator worked with Human resources to secure additional staffing agency contracts.	3/11/25

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

Electronically Signed | 03/07/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	656002	A. BUILDING: _____ B. WING _____	C 02/14/2025

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

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S 560	Continued From page 1 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 7/14/24 to 7/20/24, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: 7/14/24 had 15 CNAs for 145 residents on the day shift, required at least 18 CNAs. 7/16/24 had 17 CNAs for 145 residents on the day shift, required at least 18 CNAs. 7/17/24 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. 7/19/24 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. 7/20/24 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs.	S 560	" All residents have the potential to be affected by this deficient practice. " Recruitment, retention and employee appreciation meeting was initiated and will be led by the Director of Human Resources and/or designee. " Hiring and recruitment efforts including pay for experience, online job listings, and referral bonuses are being utilized to continue to be competitive in the marketplace. " Focus on retention efforts include, but are not limited to incentive programs, career growth and educational training opportunities and employee morale incentives. " The administrator/designee will review staffing schedules weekly to ensure adequate staffing for all shifts. The results of the recruitment and retention audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	656002	A. BUILDING: _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE GARDENS REHABILITATION AND NUR	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) COMPLETE DATE
S 560	Continued From page 2 2. For the week of Complaint staffing from 12/1/24 to 12/7/24, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts and deficient in total staff for residents on 2 of 7 overnight shifts as follows: 12/1/24 had 14 CNAs for 141 residents on the day shift, required at least 18 CNAs. 12/2/24 had 16 CNAs for 141 residents on the day shift, required at least 18 CNAs. 12/3/24 had 17 CNAs for 141 residents on the day shift, required at least 18 CNAs. 12/3/24 had 9 total staff for 141 residents on the overnight shift, required at least 10 total staff. 12/5/24 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. 12/5/24 had 9 total staff for 142 residents on the overnight shift, required at least 10 total staff. 12/7/24 had 14 CNAs for 139 residents on the day shift, required at least 17 CNAs. 3. For the two weeks of staffing prior to survey from 1/19/25 to 2/1/25, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: 1/19/25 had 14 CNAs for 143 residents on the day shift, required at least 18 CNAs. 1/20/25 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. 1/22/25 had 17 CNAs for 141 residents on the day shift, required at least 18 CNAs. 1/25/25 had 17 CNAs for 141 residents on the day shift, required at least 18 CNAs. 1/26/25 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. 1/27/25 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. 1/28/25 had 9 total staff for 142 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	656002	A. BUILDING: _____ B. WING _____	C 02/14/2025

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

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S 560	Continued From page 3 overnight shift, required at least 10 total staff. 2/1/25 had 17 CNAs for 141 residents on the day shift, required at least 18 CNAs. On 2/14/25 at 9:23 AM, the surveyor interviewed the Staffing Coordinator/Human Resources (SC/HR) staff member. The SC/HR was able to recite the Certified Nursing Assistant ratios based on the regulations. The SC/HR told the surveyor, "We are meeting the ratios for the most part." The SC/HR told the surveyor time slots were filled by reaching out to current staff or utilizing one of the six agencies the facility worked with. A review of the facility's "Staffing, Sufficient and Competent Nursing" policy with a revision date of 8/2022, included...Sufficient Staff... 8. it indicated that minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing...	S 560		
S2150	8:39-31.2(e) Mandatory Physical Environment The facility shall be kept in good repair and maintained without harm or jeopardy to residents. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 2/10/25, in the presence of the facility Maintenance Director (MD), it was determined that the facility	S2150	" The LNHA had an HVAC company come down to repair the broken HVAC unit in the lobby.	4/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	656002	A. BUILDING: _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S2150	Continued From page 4 failed to maintain one heating, air conditioning unit in proper working condition. This deficient practice had the potential to affect all 141 residents and was evidenced by the following: On 2/10/25, at approximately 9:15 AM, while in the main lobby, the surveyor heard a visitor telling the Licensed Nursing Home Administrator (LNHA) that there was no heat in the main lobby. At that time, the surveyor placed a digital thermometer on a counter at a height of 30 inches above the floor. After waiting one minute, the digital thermometer stopped, and the surveyor obtained the room temperature at 54 degrees Fahrenheit (F). The surveyor also observed the lobby's thermostat on the wall registered 55 degrees F. During an interview with the MD, the MD confirmed that the heating, ventilation, air conditioning (HVAC) unit that serviced the lobby area was not working. The Licensed Nursing Home Administrator (LNHA) and MD were informed of the findings during the Life Safety Code survey exit on 2/11/25 at approximately 1:26 PM.	S2150	All residents have the potential to be affected by this deficient practice. The LNHA had a HVAC company come down to repair the HVAC system. HVAC company ordered part and is to be installed. The Maintenance Director was educated on the SAFE environment regulation 483.10(i) The results of the audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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 B. Wing	4/8/2025

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 F0557 Reg. # 483.10(e)(2) LSC	Correction Completed 03/04/2025	ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 04/03/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/14/2025	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315454 Y1	A. Building B. Wing Y2	4/8/2025 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0557	Correction	ID Prefix F0584	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(e)(2)	Completed	Reg. # 483.10(i)(1)-(7)	Completed
LSC	03/11/2025	LSC	03/04/2025	LSC	04/03/2025
ID Prefix F0658	Correction	ID Prefix F0695	Correction	ID Prefix F0755	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	03/11/2025	LSC	03/11/2025	LSC	03/11/2025
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix F0814	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed
LSC	03/11/2025	LSC	03/11/2025	LSC	03/11/2025
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/11/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/14/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
656002 Y1	A. Building B. Wing Y2	4/8/2025 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/11/2025	ID Prefix S2150 Reg. # 8:39-31.2(e) LSC	Correction Completed 04/03/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 2/14/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
656002 Y1	A. Building B. Wing Y2	4/8/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/11/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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 2/14/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING **01** B. WING _____	**02/14/2025**

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
E 000	Initial Comments Shore Gardens Rehabilitation and Nursing Center was in compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 2/10/25 and 02/11/2025. The facility was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Shore Gardens' building construction was stated to be in the 90's with no current major renovations or noted additions. The facility is a three-story building Type II (222) construction and is fully sprinklered. The facility is divided into 6-smoke zones, the 150 KW diesel generator powers approximately 40% to 50 % of the building as per the Maintenance Director. The 3-story facility utilizes 3-elevators (2-passenger and 1-service device). The building is attached to a (Closed Daycare) 1-story structure now used for storage. The attached structure cannot be entered from the nursing home and was not observed. The facility utilizes an electric fire pump to support the fire sprinkler system. There is supervised smoke detection located in	K 000		

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

Electronically Signed | 03/07/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING **01** B. WING _____	**02/14/2025**

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
K 000	Continued From page 1 the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility has 149 certified beds. At the time of the survey the census was 141.	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)	K 321		3/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING **01** B. WING _____	**02/14/2025**

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SHORE GARDENS REHABILITATION AND NURSING CENTER	**231 WARNER STREET** **TOMS RIVER, NJ 08755**

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K 321	Continued From page 2 f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 02/11/2025 in the presence of facility US FOIA (b)(6) it was determined that the facility failed to ensure that 1 of 8 fire-rated doors inspected to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced had the potential to affect the 141 residents and was evidenced by the following: On 02/10/2025 (day one of survey) during the survey entrance at approximately 8:20 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three-story building. An observation at approximately 10:53 AM revealed the corridor door leading into the Medical Records storage room had no means to self-close. The surveyor observed inside the room the following combustible products, - 45 cardboard boxes (1-inch by 32-inch by 10-inch) filled with combustible medical records. - 19 cardboard boxes (18-inch by 12-inch by 10-inch) filled with combustible medical records. - multiple medical records stored on top of filing	K 321	" A self closing device has been installed to the corridor door leading into the Medical Records storage room. " All residents have the potential to be affected by this deficient practice. " Maintenance Director checked all rooms with combustibles to ensure proper self closing hardware was installed. The results of audits completed will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING 01 B. WING _____	02/14/2025

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SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

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K 321	Continued From page 3 cabinets. At this time the surveyor measured and recorded the room to be 18-feet by 9-feet 4 inches equaling 167.94 square feet. A review of an evacuation diagram posted on the wall in the corridor which identified to pass the room is the primary and/or secondary egress route to reach an exit. The [redacted] confirmed the finding at the time of observation. The [redacted] were informed of the deficient practice during the Life Safety Code survey exit on 02/11/2025 at approximately 1:26 PM.	K 321		
K 372 SS=E	NJAC 8:39-31.2 (e) Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 372		3/11/25

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	315454	A. BUILDING 01 B. WING _____	02/14/2025

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K 372	Continued From page 4 Based on observations on 02/10/2025 in the presence of U.S. FOIA (b) (6)), it was determined that the facility failed to maintain the integrity of smoke barrier partitions for two (2) of six (6) smoke barrier walls were maintained in accordance with NFPA 101:2012 Edition, Section 19.3.6.2.3, 8.5.6, 8.5.6.2, 8.5.6.3. This deficient practice had the potential to affect all 141 residents and was evidenced by the following: On 02/10/2025 (day one of survey) during the survey entrance at approximately 8:20 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a three-story (3) building with six (6) smoke barrier walls. Observations during tour starting at approximately 9:40 AM on 02/10/2025 in the presence of the facilities' US FOIA revealed the following above the ceiling tiles of the corridor double fire rated barrier doors: 1) At approximately 9:50 AM, the surveyor observed on the 3rd. floor above the ceiling tiles by the 1-1/2 fire rated double corridor doors next to Resident room # 306 one (1) approximately 1-inch in diameter hole with wires running through the smoke barrier wall. 2) At approximately 11:15 AM, the surveyor observed on the 2nd. floor above the ceiling tiles by the 1-1/2 fire rated double corridor doors next to Resident room #206 one (1) approximately 1/2-inch in diameter hole with wires running	K 372	All identified penetrations observed without a 1/2-hour fire-rated seal closed to prevent smoke, fumes, and fire from passing through to the other smoke compartment have been sealed with fire rating sealant. All residents have the potential to be affected by this deficient practice. The Maintenance Director will double check outside vendors' work to ensure the vendors' work is done up to code. The Director of Maintenance will report the results of audits completed and submit to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING **01** B. WING _____	**02/14/2025**

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K 372	Continued From page 5 through the smoke barrier wall. This penetration was observed indicating that it was not 1/2 hour fire rated and sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The US FOIA confirmed the findings at the time of observations. The US FOIA (b)(6) were informed of the deficiency during the Life Safety Code survey exit on 02/11/2025 at approximately 1:26 PM.	K 372		
K 531 SS=F	N.J.A.C 8:39-31.2(e) Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3	K 531		3/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SHORE GARDENS REHABILITATION AND NURSING CENTER	231 WARNER STREET TOMS RIVER, NJ 08755

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K 531	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations and record review on 02/10/2025 and 02/11/2025 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to 1) Maintain emergency communications in proper working condition for 2 of 2 elevators tested in accordance with ASME/ANSI A17.3. and 2) Conform with Firefighter's Service Requirements of ASME/ANSI A17.3 and NFPA 101: 2012 Edition, Sections 19.5.3, 9.4.2 and 9.4.3. This included firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation for 2 of 2 devices. This deficient practice had the potential to affect 141 residents and was evidenced by the following: On 02/10/2025 (day one of survey) during the survey entrance at approximately 8:20 AM, a request was made to the facility's US FOIA (b)(6) how many elevators are in the building. The MD told the surveyor that there were three (3) elevators. Observations starting at approximately 9:38 AM on 02/10/2025 in the presence of the US FOIA (b) revealed the following: At approximately 9:42 AM, a test of elevator #1 emergency communication telephone was performed. When the surveyor pressed the button for the emergency communication phone, the phone dialed and there was no answer to the emergency call. After approximately 25 seconds the phone automatically disconnected. A second test was performed and the phone did not function properly, the emergency	K 531	" Emergency communication has been installed in all 3 elevators. All residents have the potential to be affected by this deficient practice. weekly checks x 12 weeks will be conducted on all 3 elevators. The results of audits completed will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 3 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING 01 B. WING _____	02/14/2025

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K 531	Continued From page 7 communication phone did not have a pre-recorded message. On 02/11/2025 at approximately 8:05 AM, a request was made to the [US FOIA redacted] to provide a copy of the Contracted Elevator Maintenance Company (CEMC) contract and to provide evidence of the elevators firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation for elevators #1 and #2). In an interview at the time, the [US FOIA redacted] stated that the CEMC does the monthly Phase I and Phase II recall test. A review of the CEMC contract reads in part, "FIREFIGHTERS SERVICE TEST If the equipment has firefighters service, you assume responsibility for performing and keeping a record of any code required tests and for the maintenance, functioning and testing of the smoke and/or heat detectors." A review of the Department of Community Affairs annual inspection reports dated 10/24/2024 identify on elevators #1, #2 and #3, Elevator Signals and communication results : Unsatisfactory. The [US FOIA redacted] confirmed the findings at the time of observation and review. The US FOIA (b)(6) were informed of the deficient practice during the Life Safety Code survey exit on 02/11/2025 at approximately 1:26 PM.	K 531		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315454	A. BUILDING **01** B. WING _____	**02/14/2025**

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K 531	Continued From page 8 NJAC 8:39-31.2(e) ASME/ANSI A17.3	K 531		

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	4/8/2025

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 K0321	Correction Completed 03/11/2025	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 03/11/2025	ID Prefix Reg. # NFPA 101 LSC K0531	Correction Completed 03/17/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 2/14/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			