PRINTED: 05/07/2025 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER SHORE GARDENS REHABILITATION AND NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 231 WARNER STREET TOMS RIVER, NJ 08755 (X4) ID PROVIDER'S PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
SHORE GARDENS REHABILITATION AND NURSING CENTER SHORE GARDENS REHABILITATION AND NURSING CENTER (A) ID (SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS Complaint #: NJ00179177, NJ00179069 Census: 143 Sample Size: 7 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. F610 IJ Based on interviews, medical records reviews, and review of other pertinent facility documentation on 11/11/2024, and 11/22/2024, it was determined that the facility documentation on 11/11/2024, and 11/22/2024, it was determined that the facility failed to investigate an allegation of leaves of the complaint of the co			315454	B. WING			C 11/22/2024	
FREE/IX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS Complaint #: NJ00179177, NJ00179069 Census: 143 Sample Size: 7 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. F610 IJ Based on interviews, medical records reviews, and review of other pertinent facility documentation on 11/11/2024, 11/12/2024, and 11/22/2024, it was determined that the facility failed to investigate an allegation of NJ Exec Order 26.4b1 (Resident #1), U.S. FOIA (b)(6) and Resident #4, who has NJ Exec Order 26.4b1 (Resident #1) FOIA (b)(6) received a grievance by email written by Resident #1 18 (DESCONDERS) received a grievance by email written by Resident #1 18 (DESCONDERS) between Resident #1 and Resident #4, who has not addressed, and an investigation was never			TATION AND NURSING CENTER		231 WARNER STREET			
Complaint #: NJ00179177, NJ00179069 Census: 143 Sample Size: 7 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. F610 IJ Based on interviews, medical records reviews, and review of other pertinent facility documentation on 11/11/2024, 11/12/2024, and 11/22/2024, it was determined that the facility failed to investigate an allegation of TISECO Order 26.4b1 (Resident #1, U.S. Folk (b)) and Resident #4, who has IN Exact Order 26.4b1 (Resident #15 NUSCONGE 36.4b1) which included an allegad of the condition of the condi	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	LD BE	(X5) COMPLETION DATE	
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Sample Size: 7 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. F610 IJ Based on interviews, medical records reviews, and review of other pertinent facility documentation on 11/11/2024, 11/12/2024, and 11/22/2024, it was determined that the facility failed to investigate an allegation of IN Exec Order 26.4b1 residents, a IN Exec Order 26.4b1 (Resident #1), US. FOIA (b)(6) and Resident #4, who has IN Exec Order 26.4b1		Complaint #: NJ00	179177, NJ00179069					
THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. F610 IJ Based on interviews, medical records reviews, and review of other pertinent facility documentation on 11/11/2024, 11/12/2024, and 11/22/2024, it was determined that the facility failed to investigate an allegation of NJ Exec Order 26.4b1 (Residents, a NJ Exec Order 26.4b1 (Resident #1), U.S. FOIA (b) (6) and Resident #4, who has NJ Exec Order 26.4b1 Size order 26.4b1 Teceived a grievance by email written by Resident #1's NJ Exec Order 26.4b1 which included an alleged NJ Exec Order 26.4b1 between Resident #1 and Resident #4. The FORMING THE RESIDENT OF THE		Census: 143						
COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. F610 IJ Based on interviews, medical records reviews, and review of other pertinent facility documentation on 11/11/2024, 11/12/2024, and 11/22/2024, it was determined that the facility failed to investigate an allegation of NJ Exec Order 26.4b1 (Resident #1), J.S. FOIA (b)(6) and Resident #4, who has NJ Exec Order 26.4b1 (Resident #1), On Description at 8:35 p.m., the US FOIA (b) (6) received a grievance by email written by Resident #1's NJ Exec Order 26.4b1 between Resident #1 and Resident #4. The process of the provided the email to the provided of the provided o		Sample Size: 7						
and review of other pertinent facility documentation on 11/11/2024, 11/12/2024, and 11/22/2024, it was determined that the facility failed to investigate an allegation of NJ Exec Order 26.4b1 residents, a NJ Exec Order 26.4b1 (Resident #1), U.S. FOIA (b)(6) and Resident #4, who has NJ Exec Order 26.4b1 . On NJ Exec Order 26.4b1 which included an alleged NJ Exec Order 26.4b1 which included an alleged NJ Exec Order 26.4b1 between Resident #1 and Resident #4. The NJ Exec Order 26.4b1 between Resident #1 and Resident #4. The NJ Exec Order 26.4b1 which included the email to the NJ Exec Order 26.4b1 between Resident #1 and Resident #4. The NJ Exec Order 26.4b1 which included an alleged NJ Exec Order 26.4b1 between Resident #1 and Resident #4. The NJ Exec Order 26.4b1 between Resident #1 and Resident #4. The NJ Exec Order 26.4b1 which included an alleged NJ Exec Order 26.4b1 between Resident #3 and Resident #4. The NJ Exec Order 26.4b1 which included an alleged NJ Exec Order 26.4b1 between Resident #4 and Resident #4. The NJ Exec Order 26.4b1 which included an alleged NJ Exec Order 26.4b1 between Resident #4 and Resident #4.		COMPLIANCE WIT 42 CFR PART 483, TERM CARE FACII COMPLAINT VISIT	TH THE REQUIREMENTS OF SUBPART B, FOR LONG LITIES BASED ON THIS					
		and review of other documentation on 1 11/22/2024, it was of failed to investigate NJ Exec Order 26.4 residents, a NJ Exec (Resident #1), U.S. NJ Exec Order 26.4 8:35 p.m., the US Femail written by Rewhich included an abetween The Servance forwards between The Servance. However addressed, and an initiated into the allessed.	pertinent facility 11/11/2024, 11/12/2024, and determined that the facility an allegation of that the facility between two sec Order 26.4b1 TOIA (b) (6) The conder 26.4b1 Tolia (b) (6) The conder 26.4b1 The conder				(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 12/23/2024

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

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F 000 Continued From page 1 The facility's failure to address the grievance and investigate the MJ Exec Order 26.451 and follow its policies titled "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigation," "Abuse Prevention Program," the "Grievance Policy and Procedure" and the fresidents in an immediate jeopardy (IJ) situation. This IJ was identified and reported to the facility's U.S. Folk (I) (I) (I) (II) and immediate jeopardy (IJ) situation. This IJ began on immediate jeopardy (IJ) situation. This IJ began	<u> </u>	to . o.t.medio/title	U INIEDIO/ (ID OEI (VIOEO					2222 0001
NAME OF PROVIDER OR SUPPLIER SHORE GARDENS REHABILITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 Continued From page 1 The facility's failure to address the grievance and investigate the [M] Exec Order 28-851 and follow its policies titled "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigation," "Abuse Prevention Program," the "Grievance Policy and Procedure" and the sisue. The IJ began on a information about the issue. The IJ began on a large and an acceptable Removal Plan to the New Jersey Department of Health. This deficient practice was identified for 1 of 7 residents (Resident #1 On 11/29/2024, the Surveyor verified the Removal Plan, which included infolloded information about the facility implemented the Removal Plan, which included the following: Initiating an investigation related to the grievance/ allegation of the New Jersey Department of Health. This deficient practice was identified for 1 of 7 residents (Resident #1 On 11/29/2024, the Surveyor verified the Removal Plan, which included the following: Initiating an investigation related to the grievance/ allegation of the United State of the Investigation, the facility submitted an austylation, the facility submitted the allegation of the Investigation, the facility submitted the following: Initiating an investigation related to the grievance/ allegation of the Investigation, the facility submitted the following: Based on the outcome of the investigation, the facility submitted the facility submitted the facility was unable to substantiate the allegation of IN Investigation and			` '	l ' '			. ,	
NAME OF PROVIDER OR SUPPLIER SHORE GARDENS REHABILITATION AND NURSING CENTER CAM ID SUMMARY STATEMENT OF DEFICIENCIES 231 WARNER STREET TOMS RIVER, NJ 08755			315454	B. WING	.			
SUMMARY STATEMENT OF DEFICIENCIES HEEFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 Continued From page 1 The facility's failure to address the grievance and investigate the [NI Exec Orger 26.401] and follow its policies titled "Abuse. Neglect, Exploitation or Misappropriation-Reporting and Investigation," "Abuse Prevention Program," the "Grievance Policy and Procedure" and the analysis of the sisue. The IJ began on immediate jeopardy (IJ) situation. This IJ was identified and reported to the facility's p.m. The was presented with the IJ template, which included information about the issue. The IJ began on immediate jeopardy (IV) situation when the facility submitted an acceptable Removal Plan to the New Jersey Department of Health. This deficient practice was identified for 1 of 7 residents (Resident #1 On 11/29/2024, the Surveyor verified the Removal Plan, which included the following: Initiating an investigation related to the grievance/ allegation of the IN Exec Order 26.4b1 Based on the outcome of the investigation, the facility was unable to substantiate the allegation of Number of Proposition of Number of Proposition in the American State of Proposition in the Internation in Internation in the Internation in Inter	NAME OF S	DOMBED OF CHEST ISS	013434	1	_	TOTAL ADDRESS OFTW. STATE 312 SSSS	11/4	2212024
FOOD Continued From page 1 The facility sfailure to address the grievance and investigate the IN Exec Order 28.451 and follow its policies titled "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigation," "Abuse Prevention Program," the "Grievance Policy and Procedure" and the Execution and But the IN Exec Order 28.451 p.m. The International Program, "The "Grievance Policy and Procedure" and the Execution and Investigation, This IJ was identified and reported to the facility's International Program of Investigation and Investigation and Investigation and Investigation and Investigation and Investigation and Investigation or Investigation and Invest			TATION AND NURSING CENTER		23	31 WARNER STREET		
The facility's failure to address the grievance and investigate the [NJ Exec Order 26.45] and follow its policies titled "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigation," "Abuse Prevention Program," the "Grievance Policy and Procedure" and the [March 26] job description placed Resident #1 and all other residents in an immediate jeopardy (IJ) situation. This IJ was identified and reported to the facility's [M.S. FOIA (D)6] on [March 26] on [Marc	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
Completing an assessment related to any signs and symptoms of NJ Exec Order 26.4b1. Initiating in-services for the and all staff on the facility's policy on Abuse and Neglect, Investigating and Reporting, the Abuse Prevention Program Policy, and the Grievance Policy and Procedure	F 000	The facility's failure investigate the NJ its policies titled "Al Misappropriation-R" "Abuse Prevention Policy and Procedu description placed residents in an imm This IJ was identified. S. FOIA (b)(6) p.m. The Second was template, which incissue. The IJ begar #1's NJ Exec Order 25:45 allegation and cont when the facility su Removal Plan to the Health. This deficie of 7 residents (Reson 11/29/2024, the Removal Plan was implemented the R the following: Initiating an investigallegation of the NJ Exec Order 26:41 Completing an assaund symptoms of Initiating in-services the facility's policy of Investigating and R Prevention Program	to address the grievance and Exec Order 26.4b1 and follow buse, Neglect, Exploitation or eporting and Investigation," Program," the "Grievance and the Establishment of the facility's and all other nediate jeopardy (IJ) situation. The dead and reported to the facility's at 6:15 are sented with the IJ aluded information about the non Execonder 28.4b1 when Resident emailed an acceptable when Resident emailed an acceptable e New Jersey Department of ent practice was identified for 1 ident #1 Surveyor verified the implemented. The facility emoval Plan, which included execonder 26.4b1 The forme of the investigation, the to substantiate the allegation of the substantiate the allegation of the substantiate the allegation of the investigation, the to substantiate the allegation of the investigation of the	F	000			

Auditing of the last thirty days of incidents and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		315454	B. WING		11	C /22/2024
	PROVIDER OR SUPPLIER	TATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 WARNER STREET TOMS RIVER, NJ 08755		IZZIZUZ4
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F 000		d grievances to ensure there onal unresolved investigative	F O	00		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1) §483.10(j) Grievance §483.10(j)(1) The rigrievances to the fathat hears grievance reprisal and withou reprisal. Such grieving respect to care and furnished as well as furnished, the behavesidents, and other facility stay. §483.10(j)(2) The rigrievances accordance with the session with the session with the session with the session of all grievances accordance recontained in this paraprovider must give to the resident. The include: (i) Notifying resider	ces. esident has the right to voice acility or other agency or entity es without discrimination or t fear of discrimination or vances include those with I treatment which has been so that which has not been avior of staff and of other er concerns regarding their LTC esident has the right to and the prompt efforts by the facility to the resident may have, in	F 5	85		12/23/24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315454	B. WING		- 1	C /22/2024
	PROVIDER OR SUPPLIER	TATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 231 WARNER STREET TOMS RIVER, NJ 08755		
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F 585	(meaning spoken) or grievances anonymof the grievance offican be filed, that is address (mailing ar number; a reasona completing the revito obtain a written or grievance; and the independent entitie be filed, that is, the Quality Improveme Agency and State L program or protecti (ii) Identifying a Grieresponsible for overeceiving and track conclusions; leadin by the facility; main information associal example, the identifying rievances submittivitten grievance decoordinating with stancessary in light of (iii) As necessary, the prevent further poteright while the alleginvestigated; (iv) Consistent with reporting all alleged abuse, including injund/or misapproprianyone furnishing sprovider, to the admas required by State (v) Ensuring that all	or in writing; the right to file fously; the contact information icial with whom a grievance, his or her name, business and email) and business phone ble expected time frame for ew of the grievance; the right decision regarding his or her contact information of s with whom grievances may pertinent State agency, and Organization, State Survey cong-Term Care Ombudsman on and advocacy system; evance Official who is reseeing the grievance process, ing grievances through to their g any necessary investigations taining the confidentiality of all atted with grievances, for the resident for those end anonymously, issuing ecisions to the resident; and tate and federal agencies as a f specific allegations; aking immediate action to ential violations of any resident ed violation is being §483.12(c)(1), immediately it violations involving neglect, uries of unknown source, ation of resident property, by services on behalf of the ministrator of the provider; and	F 5	85		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE COMF	PLETED
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	PROVIDER OR SUPPLIER	TATION AND NURSING CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 231 WARNER STREET FOMS RIVER, NJ 08755		
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F 585	summary statement the steps taken to is summary of the per regarding the reside as to whether the groonfirmed, any corn taken by the facility and the date the wrresidents' rigor if an outside entithe State Survey Agrorganization, or loc confirms a violation rights within its area (vii) Maintaining evinesult of all grievants a years from the issue decision. This REQUIREMENT by: C#: NJ00179177, It has the facility faile "Grievance Policy and This deficient practive residents, Resident following: 1. According to the Resident #1 was according to the Reside	at of the resident's grievance, nvestigate the grievance, a ritinent findings or conclusions ent's concerns(s), a statement rievance was confirmed or not rective action taken or to be as a result of the grievance, itten decision was issued; atte corrective action in ate law if the alleged violation that is confirmed by the facility ty having jurisdiction, such as gency, Quality Improvement cal law enforcement agency for any of these residents' a of responsibility; and dence demonstrating the ces for a period of no less than suance of the grievance NT is not met as evidenced NJ 00179069 s, record review, and review of ity documents on 11/11/2024, //22/2024, it was determined do to implement its policy titled and Procedure" and the state of the grievance of th	F 585	1. Corrective Action: On 11/26/2024, an investigation initiated by the Administrator/DON reto the grievance/allegation of NJ Exec Order 26.4b1 On 11/22/24, the Administrator/Director of Nursing inithe following in-services for all staff, the facility policy of grievances, the prevention program, misappropriation exploitation-reporting and investigat On 11/25/24, the Administrator/I educated the U.S. FOIA (b)(6) on her role and the facility policy on grievances, the abuse prevention	itiated on abuse on and ing.	
	diagnoses that incli	ided but were not limited to		program and misappropriation and		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		SURVEY PLETED
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	PROVIDER OR SUPPLIER	TATION AND NURSING CENTER	D. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE 231 WARNER STREET TOMS PINER, N.L. 08755	11/2	22/2024
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F 585	According to the Massessment tool, dhad a Brief Interview of the Resident # and NJ with NJ Exec Order 26. showed Resident # and NJ with NJ Exec Order and NJ with NJ Exec Order 20.4bi with NJ A review of the Resident and NJ with NJ Exec Order 20.4bi with NJ Exec Order 20.4bi through Interventions," including the Resident NJ Exec Order 20.4bi (NJ Exec	inimum Data Set (MDS), an atec [NJESES OTGET 20:401], Resident #1 by for Mental Status (BIMS) h indicated that the Resident's [NJESES OTGET 26:401] h indicated [NJE	F 58	,	and cident es to all tions of (6). or ected to be eg, the e will disclinical and imely enployeer of iced on ance discussed will be and Meeting.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	TIPLE CONSTRUCTION ING		E SURVEY MPLETED	
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	PROVIDER OR SUPPLIER GARDENS REHABIL	ITATION AND NURSING CENTER	•	STREET ADDRESS, CITY, STATE, ZIP C 231 WARNER STREET TOMS RIVER, NJ 08755		
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F 585	Resident #4 is NJ A review of the CF revealed under "Ir on unit occasional "Goal," indicated ' NJEXEC ORDER 26.451 through Interventions," inc Resident is interest, Use NJEXEC ORDER 26.451 pla Review of an Ema 8:35 p.m., present U.S. FOIA (b)(6) revealed document NJEXEC Order 26.451, with company and obstance went to the unknown) and obstance went to the unknown and obstance went to the room, Resident #1 and FNJEXEC Order 26.451 with the room, Resident #1 and FNJEXEC Order 26.451 with the room, Resident #1] NJE [his/her] With Instance or Instance of the room in	P initiated or Resident #1 INJECT OTHER 26.4b1 Indicator": Resident #1 INJECT OTHER 26.4b1 Indicator": Resident #1 INJECT OTHER 26.4b1 Indicator I		results of these audits, a demade regarding the need for submission and reporting. Quality Assurance and Proclimprovement Committee Mineld on January 16th, 2025	or continued The next cess feeting will be	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315454	B. WING			11/2	; 2/2024
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F 585	email from Resider U.S. FOIA (b)(6) write a grievance for Review of a "Grieva the of the interest of the in	In the state of the state of the suggested the best way to suggested the facility or matters. On Suggested the facility or facility or facility or facilit	F 5	85			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		315454	B. WING		11/2	22/2024
	PROVIDER OR SUPPLIER GARDENS REHABILI	TATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 WARNER STREET TOMS RIVER, NJ 08755		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 585	During an interview Resident #1, assign Resident MJ Exec on Interview the Management of Ma	stated that he had not ec Order 26.4b1 on 11/22/2024 at 12:02 p.m., ned CNA, stated that the Order 26.4b1 She explained that a she sident #1 and Resident #4 on 11/22/2024 at 1:43 p.m., NJ Exec Order 26.4b1, he not via email from Resident #1 did not read the complaint. On 6 a.m., he forwarded the email FOIA (b)(6) further stated, "his the stated he was not not presented by a stated he was not not not presented by a stated he was not not not presented by a stated he was not	F 5	585		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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		315454	B. WING		11	/22/2024
	ROVIDER OR SUPPLIER	ITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 231 WARNER STREET TOMS RIVER, NJ 08755	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 585	Policy and Procedu Under Policy: All R interested family high grievances that are coercion, discrimin The care, treatment to be, furnished. 3 residents, responsimembers and staff investigate, and the that it receives from grievances will be and courteously as revealed the follow responsible parties and staff should fill by written notice an grievance is verbalization to the grievances will be prompt effort to responsibility of the verbalization to the grievances will be prompt effort to responsible parties and staff should fill by written notice and grievance will be prompt effort to responsibility of the grievances will be prompt effort to responsible parties and the grievance as pure that a considered, investive answered, and late documentation of coptimum quality. Review of the facil Job Description." Universed the primer primer was a supplied to the primer was a supplied to the primer was a supplied to the facil Job Description." Universed the primer was a supplied to the facil Job Description." Universed the primer was a supplied to the facil Job Description." Universed the primer was a supplied to the facil Job Description." Universed the primer was a supplied to the primer was a supplied to the facil Job Description." Universed the primer was a supplied to the facil Job Description." Universed the primer was a supplied to the facil Job Description." Universed the facil Job Description." Universed the facil Job Description."	ity's policy titled "Grievance ure" included the following: desidents, responsible parties, ave the right to voice afree from interference, nation, or reprisal concerning: 1. Int, and services that are, or fail the behavior of other ible parties, interested family for Facility will promptly address, en respond to every grievance in all such parties. All handled as promptly, prudently, spossible. Under: "Procedure" ving: 1. All Residents, so, interested family members, en grievances by verbalizing or and employee of the facility. If a lized to an employee, it is the entered the entered by social services, entered by social services, entered by social services. The entered by social services are promptly as possible. 3. Besides all grievances are promptly igated, resolved, and are reviewed, this file will provide four continued commitment to ity's "Director of Social Service Under: the Job Summary focus of the Director of to assist in the Resident's	F 5	,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. DOILD			(c
		315454	B. WING			11/2	22/2024
	PROVIDER OR SUPPLIER	TATION AND NURSING CENTER		231 W	ET ADDRESS, CITY, STATE, ZIP CODE VARNER STREET S RIVER, NJ 08755		
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	possible level of ps the facility environm Requirements" included the psycho-social depopulation and abili- guidance to them. A perform other relate Administrator" Und 3. Keep Resident's with state and feder related duties as dis	ycho-social functioning within	F 5	585			
	NJAC 8:39-13.2(c) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:		F 6	510			12/23/24
	§483.12(c)(2) Have violations are thoro	e evidence that all alleged ughly investigated.					
	. , , ,	ent further potential abuse, n, or mistreatment while the rogress.					
	designated represe accordance with St Survey Agency, with incident, and if the appropriate correct	e administrator or his or her intative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced		1	. Corrective Action:		

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OLIVILI	TO I OIL MILDIOAIL	A MILDIOAID SERVICES			CIVID NO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG	СОМ	SURVEY PLETED
		315454	B. WING _		I	2 2/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				231 WARNER STREET		
SHORE	GARDENS REHABILI	TATION AND NURSING CENTER		TOMS RIVER, NJ 08755		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		SHOULD BE	COMPLETION DATE
F 610	Continued From pa	age 11	F 61	10		
		.9		" On 11/26/24, an investig	ation was	
	Based on interview	s, medical records reviews,		initiated by the Administrator		
	and review of other			to the grievance/allegation of		
		11/11/2024, 11/12/2024, and		NJ Exec Order 26.4b1		
	11/22/2024, it was determined that the facility			, which include a clini	cal and body	
	failed to investigate an allegation of			assessment and assessmen		
				any signs/symptoms of NJ Exec	Order 26.4b1	
	residents, a NJ Exec Order 26.4b1 resident			concern.		
	(Resident #1), NJ			" On 11/22/24, the		
		and Resident #4, who has		Administrator/Director of Nur		
		4b1 . On NJ Exec Order 28.4b1 at		the following in-services for a		
	8:35 p.m., the U.S.			the facility policy of grievance		
) received a grievance by		prevention program, misappi		
	email written by Re	esident #1's ^{NJ Exec Order 26.4b1} , alleged <mark>NJ Exec Order 26.4b1</mark>		exploitation-reporting and inv		
	which included an a	n Resident #1 and Resident #4.		" On 11/25/24, the Adminis		
		ed the email to the		educated the US FOIA (b) (6) or and the facility policy on griev	vances the	
		instructions to write a		abuse prevention program, a		
		er, the grievance was not		misappropriation and	iiiu	
		investigation was never		exploitation-reporting and inv	estigation	
	initiated into the all			• On 11/25/24 the USFOA (B) (6		
		3		reeducated by ownership on		
	The facility's failure	to address the grievance and		Grievance process, abuse pr		
		Exec Order 26.4b1 and follow		program and abuse and neg		
	its policies titled "A	buse, Neglect, Exploitation or		investigating and reporting po		
		eporting and Investigation,"				
		ntion Program," and the		" On 11/26/24, the Adminis		
		ption placed Resident #1 and		DON audited the last 30 days		
		n an immediate jeopardy (IJ)		and accident reports and grie		
		as identified and reported to		assure there were not any ac		
	the facility's U.S. F			unresolved and investigated		
		The was presented was presented		abuse and neglect identified.		
		e, which included information ne IJ began on West Order 28.461 when		" On 11/27/24, the US FOIA NJ Exec Order 26.4b1	(b) (c) was	
		c Order 26.4b1 emailed U.S. FOIA (D)(6			nev to	
		n and continued through		 Resident #4 had a tende NJ Exec Order 26.4b1 resident 		
		ne facility submitted an		facility's intervention was to		
		al Plan to the New Jersey		of resident #4		

Department of Health. This deficient practice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315454	B. WING		C 11/22/20	24
	PROVIDER OR SUPPLIER	ITATION AND NURSING CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 231 WARNER STREET FOMS RIVER, NJ 08755		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMP	X5) PLETION ATE
F 610	was identified for 1 On 11/29/2024, the Removal Plan was implemented the Fithe following: Initiating an investi allegation of the Sased on the outofacility was unable of NJ Exec Order 26.4 Completing an assand symptoms of Initiating in-service the facility's policy Investigating and Forevention Progra Policy and Proced Auditing of the last accident reports a were not any additallegations of NJ Eidentified. 1. According to the Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which in NJ Exec Order 26.4 According to the North Resident #1 was a diagnoses which	e Surveyor verified the simplemented. The facility Removal Plan, which included agation related to the grievance/ ome of the investigation, the to substantiate the allegation but. Bessment related to any signs besome and Neglect, Reporting, the Abuse m Policy, and the Grievance at thirty days of incidents and and grievances to ensure there ional unresolved investigative best of the second (AR), admitted on substantiate the allegation with included but were not limited to: 4b1 Signature (AR), with included but were not limited to: 4b1	F 610	2. Identification of other residents areas having the potential to be afficient of the deficiency: " All residents have the potential affected by this deficient practice. 3. Measures Put into Place: " During morning /clinical meetin Administrator/DON and/or designed audit through review of incident and accident investigations/reports and report for any allegations of abuse neglect or grievances that require to investigation and resolution. " Upon identification of a new enthat will assume the role of Director services, they will be in-serviced or job description/roles and responsib as well as the grievance process by Nurse Educator. • Resident #4 was care planned as needed to ensure results as needed to ensure results as needed to ensure results of audits completed. **Nesident #1 has a tendency to the resident #1 from the results of audits completed. **Jerce Order 26.4b1** **Were placed on those specific rooms to the resident #1 from the results of audits completed. **Jerce Order 26.4b1** **The results of audits completed. **Jerce Order 26.4b1** **Jerce Orde	g, the e will disclinical and imely imployeer social in their illities y the for sident	
	assessment tool, of had a Brief Interview score of the NJ Exec Order 26	Hated Hater Resident #1 Resident #1 Rew for Mental Status (BIMS) Ch indicated that the Resident's		during the morning/clinical meeting submitted to the Quality Assurance Process Improvement Committee I monthly for 3 months. Based on the results of these audits, a decision versults.	will be and Meeting e	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315454	B. WING			C 22/2024	
	PROVIDER OR SUPPLIEI GARDENS REHABII	R LITATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP 231 WARNER STREET TOMS RIVER, NJ 08755			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 610	with NJ Exec Order 28.4b1 through the through the through the through the through	J Exec Order 26.4b1 er 26.4b1 J Exec Order 26.4b1 the unit. Desident's Care Plan (CP) er 20.4b1 revealed under ent #1 "Seconder 26.4b1. Under "Goal," e a safe environment for h the next review date; Under cluded: "Involve in programs of Order 26.4b1 during overnight discussed with family who and NJ Exec Order 26.4b1 Exec Order 26.4b1 Exec Order 26.4b1 Time Plant of the unit. Will Seconder 26.4b1 and sand place Begin and seconder 26.4b1 on	F 6	made regarding the need f submission and reporting. Quality Assurance and Pro Improvement Committee M held on January 16th, 2025	The next cess Meeting will be		
	revea #4 "Uses one 25.5" on ur Under "Go environment for the control of the contr	esident's CP initiated on led under "Indicator": Resident nit occasionally "VERSO OTER 2045" through the next er Interventions," included: "Find dent is "VERSO OTER 2045" involve in the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		315454	B. WING	·	11/	/22/2024
	NAME OF PROVIDER OR SUPPLIER SHORE GARDENS REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 231 WARNER STREET TOMS RIVER, NJ 08755		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE
F 610	Review of an Emai 8:35 p.m., presente U.S. FOIA (b)(6) revealed document with incident Went to the unknown) and observent to the unknown) and observent exident #1 and Resident #1 and Resident #1] NJ Exec Order 26.4b1 with [his/her] Went to the unknown and observent exident #1] NJ Exec Order 26.4b1 with [his/her] Went and that [Resident #4] NJ Exec Order 26.4b2 further wrote that a [Resident #4] NJ Exec Order 26.4b2 fur	I Grievance dated placed on the station from Resident #1's ich included a complaint of an order 26.4b1 and the exact of the exact of the station from Resident #1 and ording to the email, the station from Resident #1 and ording to the email, the exercise that when was walked into the exact of the exercise of the exact of the exercise	Fe	610		
	NJ Exec Order 26.4					
	the U.S. FOIA (b)(6) from the userous aboreached out to the	ance Timeline," undated from , she received an email out a grievance; she then by Exec Order 26.451 by telephone suggested the best way to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED C	
		315454	B. WING			/22/2024
	VIDER OR SUPPLIER	TATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 WARNER STREET TOMS RIVER, NJ 08755		ZEIZUZT
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
Du the recass was her	ave an Interdisciple eeting. The was co take care of othe initiated a "Recescribes, "Investigken place for more execorder 26.4bl was CT meeting via e was could not a uring an interview e NJ Exec Order stated Resident #1 has been esident #1 has been exident #4 stated exident #1, assign exident #1, assig	sues on the grievance is to inary Care Team (IDCT) Order 26.4b1, in return, informed ming in person to the facility r matters. On the facility of the faci	F6	10		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		315454	B. WING			1	C 1/22/2024
	PROVIDER OR SUPPLIER	TATION AND NURSING CENTER		231 WARNE	RESS, CITY, STATE, ZIP CODE R STREET ER, NJ 08755		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTOR ACTION SHO SS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 610	had never seen Retogether. During an interview the stated or received a complain stated or received a complain stated or received a complain stated or received a the stated or received at 10:00 to the stated or received at 10:00 to the stated or stated or received at 10:00 to the stated or stated or received at 10:00 to the stated or received at 10:00 to the stated or received or received aware of the grieval of Resider the stated or received or	y on 11/22/2024 at 1:43 p.m., NJ Exec Order 26.4b1 he nt via email from Resident #1 did not read the complaint. On 6 a.m., he forwarded the email FOIA (b)(6) further stated, "his r the stated the agrievance. y on 11/22/2024 at 1:53 p.m.,	F6	10			
	the stated on received an email from an allegation of NJ between Re and Resident #4 (N) further stated sunit, as she actively #1's family. She fur speak to the nurses U.S. FOIA (b)(6). Review of an undar Neglect, Exploitation Misappropriation-Rincluded the following All reports of Residunknown origin), neglective missing and the state of th	ted facility policy titled; "Abuse,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	TATION AND NURSING CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 231 WARNER STREET FOMS RIVER, NJ 08755	11112	LIZUZA
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE	(X5) COMPLETION DATE
F 610	reported to local starequired by current investigated by facial investigations ar reported. Under "Polimplementation" In allegations are thor Administrator initial Investigations may trained in reviewing such allegations. 4 responsible for keer representative (spoof the investigation that the Resident a suspected violation or reprisal by the all anyone associated Review of the facility Prevention Program Under the "Policy Strevealed, "Our Restrom abuse, negled property and exploit limited to freedom involuntary seclusic physical abuse, and not required to treat Under "Policy Interpincluded As part of prevention, the administration of the property included As part of prevention, the administration of the residents from abunecessarily limited residents, consultated other agencies, fan representatives, frieindividual. 2. Development of the property of the prevention	ate and federal agencies (as regulations) and thoroughly lity management. Findings of and documentation are olicy Interpretation and vestigating Allegations: 1. All roughly investigated. The rese investigations. 2. It is assigned to an individual and investigating, and reporting and the Administrator is ping the Resident and his/her report informed of the progress. 5. The Administrator ensures and the person(s) reporting the are protected from retaliation leged perpetrator, or by with the facility. The Administrator ensures are protected from retaliation leged perpetrator, or by with the facility. The Administrator ensures are protected from retaliation leged perpetrator, or by with the facility. The Administration of resident are protected the following: the facility. The Administration of resident are protected from retaliation leged perpetrator, or by with the facility. The Administrator ensures are protected from retaliation leged perpetrator, or by with the facility.	F 610			
	other agencies, fan representatives, frie individual. 2. Devel	nily members, legal ends, visitors, or any other				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	CON	(X3) DATE SURVEY COMPLETED C		
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	PROVIDER OR SUPPLIER	TATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 231 WARNER STREET TOMS RIVER, NJ 08755			
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F 610	Continued From pa	age 18	F 61	0			
	Identify and investigabuse. 4. Protect reinvestigations. Review of the facility ob Description."	tment of our residents. 3. gate all possible incidents of esidents during abuse ty's "Director of Social Service Inder: the Job Summary ary focus of the Director of					
	Social Services is tadjustment to the facility environn Requirements" include the psycho-social oppulation and abiliguidance to them. Administrator" Ur 3. Keep Resident's with state and fede	o assist in the Resident's acility and maintain the highest ycho-social functioning within					
	Description." The "I revealed: 1. The pris to direct the dayin accordance with local standards, gu govern nursing faci degree of quality caresidents at all time Authority" included: delegated the admiresponsibility, and a carrying out your as Function" showed: to identify the essel However, it in no w	s "Administrator Job Purpose of Your Job Position" imary purpose of your position to-day functions of the facility current federal, state, and idelines, and regulations that ilities to assure that the highest are can be provided to our es. Under " Delegation of 1. As Administrator you are inistrative authority, accountability necessary for ssigned duties. Under: " Job 1. Every effort has been made ntial functions of this position. ray states or implies that these you will be required to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315454	B. WING			2/2024
	PROVIDER OR SUPPLIER	TATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 WARNER STREET TOMS RIVER, NJ 08755		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 610	duties does not extended the work is similar, function of the post Responsibilities." "included: 1. Develor and procedures and practice that gover Assist department use and implement and procedures and practices. 4. Interporcedures to emprecedures to emprecedures to emprecedures to emprecedures to emprecedures, visitors, necessary. 5. Ensuresidents, visitors, the facility's establiation of the facility's establiation of the facility's establiation of the facility in the fac	sion of specific statements of clude them from the position if related, or is an essential ition. Under the "Duties and Administrative Function" op and maintain written policies d professional standards of an the operation of the facility. 2. directors in the development, tation of departmental policies d professional standards of ret the Facility's policies and professional standards of ret the Facility's policies and ployees, residents, family government agencies, etc., as are that all employees, and the general public follow shed policies and procedures. The etions to discuss survey ation of plans of action and the "Personnel Function" ate Administrative authority, accountability to other staff ned necessary to perform their Review accident and incident injuries of an unknown source, or to determine the efacility's risk management desident Rights "included 1. omplaints and grievances and ts of action taken. Discuss esident and family as	F 610			
F 835	NJAC 8:39-9.4(f) Administration		F 835	5	1	12/23/24

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER SHORE GARDENS REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 231 WARNER STREET TOMS RIVER, NJ 08755	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 835	S483.70 Administra A facility must be a enables it to use its efficiently to attain practicable physica well-being of each This REQUIREME by: C#:NJ 00179177, Based on interview review, and review documentation on 11/11/2024, it was Administration faile complete investiga allegation of NJ Exand follow its Abus and Reporting, the Policy, the Grievan the Administrator's This deficient pracresidents (Resident pracresidents (Resident pracresidents (Resident pracresidents (Resident #1 was adiagnoses which in NJ Exec Order 26.	dministered in a manner that a resources effectively and or maintain the highest all, mental, and psychosocial resident. NT is not met as evidenced NJ 00179069 Tes, Medical Record (MR) of pertinent facility 11/11/2024, 11/12/2024 and determined that the facility's ad to ensure a thorough and tion was completed for an acc Order 26.4b1 Te and Neglect, Investigating Abuse Prevention Program ce Policy and Procedure, and Job Description. Tice was identified for 2 of 7 that and Resident #4) and was collowing: Temperature of the manner of the manner of the maintain was accorded to the maintain with the cluded but were not limited to:	F 83	1. Corrective Action: On 11/25/2024, the US FOIA (b) educated on his job description, roresponsibilities to ensure that policiprocedures and effective systems implemented to assure that thorou complete investigations are compliallegations of resident-to-resident abuse. On11/25/2024, the US FOIA (b) educated on the following policies: and Neglect Policy, Investigating a Reporting Policy, The Abuse Preve Program Policy and Grievance Policy. Identification of other residents areas having the potential to be afficulted to the nature of the deficiency: All residents have the potential affected by this deficient practice. 3. Measures Put into Place: The LNHA/designee will conduced weekly audits/review of any grieval and allegations of sexual abuse to timely implementation of investigating resolution has occurred. 4. How Will These Actions Be	les, and sies and were gh and eted for sexual (6) was Abuse and ention licy. I to be uct nces assure	

PRINTED: 05/07/2025 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	315454	B. WING		C
	313434			11/22/2024
NAME OF PROVIDER OR SUPPLEMENT SHORE GARDENS REHAE	IER Bilitation and nursing center	,	STREET ADDRESS, CITY, STATE, ZIP CODE 231 WARNER STREET TOMS RIVER, NJ 08755	
PREFIX (EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFEDER OF T	D BE COMPLETION
U.S. FOIA (b)(6 showed Reside and with With A review of the Wiese Order 28.4b1 with A review of the Wiese Order 28.4b1 reve #1 "Wiese Order 28.4b1 reve #1 "Nu exec Order 28.4b1 reve #1 "Involve in prog during of during of discussed with the NJ Exec Order will and Place According to the on Wiese Order 28.4b1 reve were not limited According to the Resident #4 had which indicated Resident #4 is A review of the	which indicated that the Resident's I. The MDS also Int #1 needed NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 I. and I. and I. and I. Exec Order 26.4b1 I. and I. and I. Exec Order 26.4b1 I. The MDS also showed I. I. The MDS also showed I. Exec Order 26.4b1 I. The MDS also showed I. Exec Order 26.4b1 I. The MDS also showed I. Exec Order 26.4b1 I. The MDS also showed I. Exec Order 26.4b1 I. The MDS also showed I. Exec Order 26.4b1 I. The MDS also showed I. Exec Order 26.4b1 I. The MDS also showed I. Exec Order 26.4b1 I. The MDS also showed I. Exec Order 26.4b1 I. The MDS also showed I. Exec Order 26.4b1 I. Exec Order 26.4b1 I. I. Exec Order 26.4b1	F 835	Measured: • The results of the weekly audibe submitted to the Quality Assura Process Improvement Committee monthly for 3 months. Based on tresults of these audits, a decision made regarding the need for contisubmission and reporting. The net Quality Assurance and Process Improvement Committee Meeting held on January 16th, 2025.	ance and Meeting he will be inued ext

through the next review date; Under

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD	TIPLE CONSTRUCTION DING	CON	(X3) DATE SURVEY COMPLETED C	
		315454	B. WING			/22/2024
	PROVIDER OR SUPPLIER	TATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 231 WARNER STREET TOMS RIVER, NJ 08755		LLILULT
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 835	Interventions," inclu Resident NJ Exec Order 26.4 NJ Exec Order 26.4 Review of an Email 8:35 p.m., presente U.S. FOIA (b)(6) revealed document NJ Exec Order 26.4b1, who incident NJ Exec Order 26.4b1, who incident HA. Accordate to the unknown) and observed to the unknown) and observed to the unknown) and observed to the unknown, Resident #1 and Resident #1 and Resident #1] NJ Exec Order 26.4b1 further wrote that a [Resident #4] NJ Exec Order 26.4b1 further wrote that a [Resident #4] NJ Further review of th NJ Exec Order 26.4b write a grievance for During an interview	ded: "Find out what the ded: "Find out what the moder 26.4b" at doorway and ded: "All of the Surveyor from the ation from Resident #1's ich included a complaint of an red between Resident #1 and ding to the email, the except the door closed with esident #4 in the room. The te that when walked into #4 NJ Exec Order 26.4b1 e continued, "I then found my dec Order 26.4b1" The NJ Exec Order 26.4b1 staff member "told me dec Order 26.4b1 sident #1 NJ Exec Order 26.4b1 sident #1 NJ Exec Order 26.4b1 in the moder was order 26.4b1 or the moder and showed that on the modern and showed t		335		
		Exec Order 26.4b1 ., he nt via email from Resident #1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED C	
		315454	B. WING		1.	1/22/2024
	PROVIDER OR SUPPLIER	TATION AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP O 231 WARNER STREET TOMS RIVER, NJ 08755		112212027
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 835	further stated on Notes forwarded the email U.S. FOIA (b)(6) said by said to do a full investigation of Notes forwarded the email forwarded the email forwarded an interview the property stated on received an email for an allegation of Notes for further stated so unit, as she actively #1's family. She fur speak to the U.S. Forward for the property of the property o	did not read the complaint. He J Exec Order 26.4b1, he if to the useron In addition, the This expectation was for the estigation and write a Ton 11/22/2024 at 2:11 p.m., J Exec Order 26.4b1 she from the useron which included Exec Order 26.4b1 J Exec Order 26.4b1). The she spoke with the CNAs in the tries to reach out to Resident ther stated that she did not OIA (b)(6)		335		
	Neglect, Exploitation Misappropriation-R included the followin All reports of Residunknown origin), netheft/misappropriation reported to local starequired by current investigated by facinal investigations are reported. Under "Pollimplementation" Invallegations are thor Administrator initiat Investigations may trained in reviewing such allegations. 4. responsible for keepolicy included in the support of the s	red facility policy titled; "Abuse, n or eporting and Investigation," ang: Under: "Policy Statement: ent abuse (including injuries of eglect, exploitation, or on of resident property are ate and federal agencies (as regulations) and thoroughly lity management. Findings of ad documentation are olicy Interpretation and estigating Allegations: 1. All oughly investigated. The es investigations. 2. be assigned to an individual investigating, and reporting The Administrator is ping the Resident and his/hermsor) informed of the progress				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED		
		315454	B. WING_		11	C / 22/2024		
NAME OF PROVIDER OR SUPPLIER SHORE GARDENS REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP C 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)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIA		N SHOULD BE	(X5) COMPLETION DATE
F 835	of the investigation that the Resident a suspected violation or reprisal by the all anyone associated. Review of the facilit Policy and Procedu Under Policy: All Reinterested family has grievances that are coercion, discrimina The care, treatmen to be, furnished. 3. residents, responsimembers and staff investigate, and the that it receives from grievances will be hand courteously as revealed the following responsible parties and staff should file by written notice an grievance is verbalization to the grievances will be in prompt effort to result All grievances will be in prompt effort to result all grievance as promaking sure that all considered, investiganswered, and late documentation of optimum quality.	. 5. The Administrator ensures nd the person(s) reporting the are protected from retaliation leged perpetrator, or by	F 83	35				

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315454	B. WING		- 1	22/2024	
	PROVIDER OR SUPPLIER	ITATION AND NURSING CENTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 31 WARNER STREET TOMS RIVER, NJ 08755	<u>,</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 835	Prevention Program Under the "Policy solution abuse, negleter property and exploit limited to freedom involuntary seclusing physical abuse, and not required to treat Under "Policy Interinctuded As part of prevention, the addresidents from abunecessarily limited residents, consultated other agencies, fair representatives, friedividual. 2. Dever procedures to aid neglect, or mistreat Identify and investigation."	m " revealed the following: Statement" section the policy sidents have the right to be free ct, misappropriation of resident bitation. This includes but is not from corporal punishment, on, verbal, mental, sexual, or ad physical or chemical restraint at the Resident's symptoms. The Resident abuse ministration will: 1. Protect our use by anyone including, but not to: facility staff, other ants, volunteers, staff from mily members, legal itends, visitors, or any other lop and implement policies and our facility in preventing abuse, atment of our residents. 3. ites all possible incidents of residents during abuse.					
	Description." The revealed: 1. The prist to direct the day in accordance with local standards, gugovern nursing fact degree of quality cresidents at all time. Authority" included delegated the admiresponsibility, and carrying out your a Function" showed:	s "Administrator Job 'Purpose of Your Job Position" rimary purpose of your position -to-day functions of the facility a current federal, state, and uidelines, and regulations that cilities to assure that the highest are can be provided to our es. Under " Delegation of 1: 1. As Administrator you are ninistrative authority, accountability necessary for assigned duties. Under: " Job 1. Every effort has been made ential functions of this position.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315454	B. WING			l	C
NAME OF F	PROVIDER OR SUPPLIER	313434	D. WING		EET ADDRESS, CITY, STATE, ZIP CODE	11/2	22/2024
SHORE GARDENS REHABILITATION AND NURSING CENTER				231	WARNER STREET MS RIVER, NJ 08755		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 835	are the only duties perform. The omiss duties does not excite work is similar, function of the posit Responsibilities." A included: 1. Develo and procedures and practice that govern Assist department of use and implement and procedures to employ members, visitors, a necessary. 5. Ensuresidents, visitors, a the facility's establis 8. Conduct daily meduring Facility inspefinding and formula correction. Under the revealed: 1. Delegaresponsibility, and a personnel as deem assigned duties. 1. reports (e.g., falls, in abuse, etc.). Monito effectiveness of the program. Under "Review resident comake written reports."	ay states or implies that these you will be required to sion of specific statements of clude them from the position if related, or is an essential tion. Under the "Duties and Administrative Function" p and maintain written policies of professional standards of a the operation of the facility. 2. directors in the development, ation of departmental policies of professional standards of the Facility's policies and toyees, residents, family government agencies, etc., as are that all employees, and the general public follow shed policies and procedures. The professional standards of the the facility's policies and toyees, residents, family government agencies, etc., as are that all employees, and the general public follow shed policies and procedures. The professional Function "I the Administrative authority, accountability to other staff and necessary to perform their Review accident and incident injuries of an unknown source,	F	335			

N.J.A.C. 8:39-13.1 (a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		315454	B. WING		C 11/22/2024	
NAME OF PROVIDER OR SUPPLIER SHORE GARDENS REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 231 WARNER STREET TOMS RIVER, NJ 08755	THEELECT	
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	

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New Jersey Department of Health
STATEMENT OF DEFICIENCIES (X1) PI

` '		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED					
		656002		B. WING		11/2	; 2/2024		
NAME OF E	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY S	STATE, ZIP CODE				
	231 WARNER STREET								
SHORE	GARDENS REHABILI	TATION AND NUR	TOMS RIV	/ER, NJ 087	55				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE		
S 000	Initial Comments			S 000					
S 560	standards in the Ne Chapter 8:39, Stand Term Care Facilities Plan of Correction, for each deficiency implemented. Failu result in enforcementhe provisions of the		tive Code, f Long ubmit a on date blan is cies may ce with strative	S 560			12/23/24		
	State, and local law This REQUIREMEN	mply with applicable lost, rules, and regulation	ons.						
	11/22/2024, it was of failed to ensure star maintain the require ratios as mandated 16 day shifts and 1 practice was evider Reference: New Jet (NJDOH) memo, dowith N.J.S.A. (New 30:13-18, new mininursing homes," inc	pertinent facility 11/11/2024, 11/12/202 determined that the fa ffing ratios were met ed minimum staff-to-r by the state of New night shift. The defici nced by the following: ersey Department of h ated 01/28/2021, "Co Jersey Statutes Anno mum staffing requirer dicated the New Jerse to law P.L. 2020 c 112	acility to resident Jersey for ient Health mpliance otated) ments for		 1. Staffing coordinator was ed on New Jersey state staffing ratio requirements on 12/20/2024. Efforts to hire facility staff will ountil there is adequate staff to mean minimum staff to resident ratios. Utime, the facility will use staffing agand offer additional shifts to currer with bonuses as required. Facility Administrator worked thuman resources to secure additistaffing agency contracts. Interdisciplinary team met on 12/23/2024, to discuss recruitmen retention interventions. 	continue et the Intil that gencies nt staff with onal			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE **Electronically Signed** TITLE

(X6) DATE 12/23/24

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New Jersey Department of Health

New Jersey Department of Fleatin							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,		(X3) DATE			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED			
					l c	:	
		656002	B. WING			2/2024	
					11/2	LIZUZ	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
SHOPE	SHORE GARDENS REHABILITATION AND NUR						
SHOKE	SANDENS NEITABILI	TOMS RIV	ER, NJ 087	55			
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PRÉFIX	,	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE	
				,			
S 560	Continued From pa	ige 1	S 560				
	codified as N.J.S.A.	. 30:13-18 (the Act), which					
		m staffing requirements in		2. Identification of other residents	sor		
		e following ratio (s) were		areas having the potential to be af			
	effective on 02/01/2			due to the nature of the deficiency			
	CHCOUVE OH 02/01/2	1021.		All residents have the potential			
				affected by this deficient practice.	i to be		
	One Certified Nurse	e Aide (CNA) to every eight		and deficient practice.			
		y shift. One direct care staff		3. Measures Put into Place:			
		0 residents for the evening		Recruitment, retention and em	nlovee		
		no fewer of all staff members		appreciation meeting was initiated			
		each direct staff member shall		be led by the Director of Human	and will		
		as a certified nurse aide and		Resources and/or designee.			
		aide duties: and one direct		Hiring and recruitment efforts			
		to every 14 residents for the		including pay for experience, onlin	e iob		
		I that each direct care staff		listings, and referral bonuses are b			
		in to work as a CNA and		utilized to continue to be competiti			
	perform CNA duties			marketplace.			
	p			Focus on retention efforts inclination	ude but		
	For the 2 weeks of	staffing prior to survey from		are not limited to incentive program			
		92024, the facility was deficient		career growth and educational trai			
		residents on 8 of 14 day shifts		opportunities and employee moral			
	as follows:			incentives.	_		
				The administrator/designee with	II review		
	-10/27/24 had 16 C	NAs for 143 residents on the		staffing schedules weekly to ensur			
	day shift, required a			adequate staffing for all shifts.			
		NAs for 142 residents on the					
	day shift, required a			4. How Will These Actions Be Me	easured:		
		NAs for 142 residents on the		The results of the recruitment		l	
	day shift, required a			retention audits will be submitted t			
		NAs for 142 residents on the		Quality Assurance and Process			
	day shift, required a			Improvement Committee Meeting	monthly		
				for 3 months. Based on the result	-		
	-11/03/24 had 17 C	NAs for 142 residents on the		these audits, a decision will be ma	de	l	
	day shift, required a	at least 18 CNAs.		regarding the need for continued		l	
		NAs for 141 residents on the		submission and reporting. The ne	xt	l	
	day shift, required a	at least 18 CNAs.		Quality Assurance and Process			
		NAs for 141 residents on the		Improvement Committee Meeting	will be		
	day shift, required a	at least 18 CNAs.		held on January 16th, 2025.			
		NAs for 141 residents on the					
day shift, required at least 18 CNAs.							

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New Jersey Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			·		С			
		656002	B. WING			22/2024		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
SHORE	GARDENS REHABILI	TATION AND NUR	ARNER STREE RIVER, NJ 087					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE		
S 560	Continued From page 2		S 560					
	10/27/2024 to 11/09 deficient in minimul days as follows: For the week of 10/09 Required Total Staff -10/27/24 had 392 difference of -38.94 -11/02/24 had 416 adifference of -14.94 For the week of 11/09 Required Total Staff - 11/03/24 had 408	actual staffing hours, for a hours. actual staffing hours, for a hours. actual staffing hours, for a hours. 03/24 fing Hours: 419.96 actual staffing hours, for a						
	difference of -11.96 - 11/09/24 had 416 difference of -3.96 l	actual staffing hours, for a						

STATE FORM: REVISIT REPORT MULTIPLE CONSTRUCTION PROVIDER / SUPPLIER / CLIA / DATE OF REVISIT **IDENTIFICATION NUMBER** A. Building 1/2/2025 656002 B. Wing **Y3** NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE SHORE GARDENS REHABILITATION AND NURSING CENTER 231 WARNER STREET TOMS RIVER, NJ 08755 This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form). ITEM DATE ITEM DATE ITEM DATE **Y4 Y5** Y4 Y5 Y4 **Y**5 ID Prefix S0560 **ID Prefix ID Prefix** Correction Correction Correction 8:39-5.1(a) Reg. # Completed Reg. # Completed Reg. # Completed LSC 12/23/2024 LSC LSC **ID Prefix ID Prefix ID Prefix** Correction Correction Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC ID Prefix Correction ID Prefix Correction ID Prefix Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC ID Prefix Correction **ID Prefix** Correction **ID Prefix** Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **ID Prefix ID Prefix ID Prefix** Correction Correction Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **REVIEWED BY REVIEWED BY** DATE SIGNATURE OF SURVEYOR DATE STATE AGENCY (INITIALS) **REVIEWED BY** DATE TITLE DATE **REVIEWED BY** CMS RO (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

Page 1 of 1 EVENT ID: CPKT12

YES NO

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

11/22/2024