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	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shore Gardens Rehabilitation and Nursing Center	231 Warner Street Toms River, NJ 08755

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** REPEAT DEFICIENCY Complaint #: NJ185836; NJ186066 Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the facility was maintained to provide the residents with a safe, clean, comfortable and homelike environment. This deficient practice was identified on 3 of 3 nursing units, and was evidenced by the following: On 5/8/25 from 9:40 AM to 10:40 AM, the surveyor toured the Second-floor nursing unit and observed the following: 1. In Resident room [ROOM NUMBER], the wall paper was peeling off the wall behind the door. 2. In Resident room [ROOM NUMBER]'s bathroom, the bathroom ceiling tiles were cracked, the grab bar (bar affixed to the wall for safety) on the left side of the toilet was coming off the wall, the paint was peeling from the left side of the sink and the right side of the soap dispenser, the paint was peeling on the inside of the bathroom door and there were black marks on the lower section of the door. Above Bed-A in the right corner, the ceiling tile was stained brown, and the nightstand, wardrobe closet and television (TV) stand dresser all had paint peeling. 3. At 9:59 AM, the surveyor observed a blackish/brown stain around the inside of the toilet bowl of Resident room [ROOM NUMBER]. At that time, the surveyor asked the Licensed Practical Nurse (LPN #1) to accompany them into Resident room [ROOM NUMBER]'s bathroom, and the surveyor asked what that substance was. LPN #1 stated all toilets look like that, and that the housekeeping staff cleaned the toilets, but it did not come off. The surveyor asked if the facility was aware of the stain, and LPN #1 stated she would assume the facility was aware, and in her opinion, the facility did not think it was an issue. 4. In Resident room [ROOM NUMBER], the two TV stand dressers, the wardrobe closet, and the chair positioned by the window for Bed-B all had paint peeling off and the chair cushion was stained. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. In Resident room [ROOM NUMBER], the baseboard trim was peeling and the wallpaper was coming off when entering the room, and the paint was peeling behind the door. By Bed-A, the corner trim was missing and the nightstand door was coming off. In the bathroom, inside the toilet bowl was stained brownish, the hand rail to the side of the toilet was coming off, the paint was peeling off the back of the bathroom door, and by the right of the exit, the bottom of the wall (sheet rock) was crumbling off. 6. At 10:05 AM, Resident #1 reported and showed the surveyor that the bottom left drawer of their wardrobe closet was a fake drawer. Resident #1 pulled the drawer out and showed that the drawer had no bottom, it was just a frame. Resident #1 also stated that the left wardrobe closet door did not close. The surveyor asked if staff were aware, and Resident #1 stated that staff attempted to close it every time they walked by and it did not close. Resident #1 then showed the surveyor blackish colored stains on the floor between the three dressers, and stated that the room next to them had a water leak that came into their room, and the facility never cleaned it. Resident #1 also showed the surveyor their air conditioner (AC) unit that was soiled with dust, food debris, and a thumbtack. 7. In Resident room [ROOM NUMBER], the paint was peeling off the left side by the entrance to the room, the two TV stand dressers had paint peeling off, and the right wardrobe closet door did not close. Inside the bathroom, the toilet bowl was stained a blackish/brown color, the paint was peeling off the walls, there were holes in the wall, left lower trim was missing, the wall was peeling under the soap dispenser, the mirror was peeling, and the hand rail by the toilet was coming off. 8. The Second-floor dayroom had paint peeling at the entrance, wallpaper was peeling off underneath the windows, the paint was peeling off the trim to both door frames and off both doors. All eight chairs had soiled arms and stained seats. The five tables all had peeling paint. 9. In Resident room [ROOM NUMBER], the wallpaper was peeling off by entrance inside, the right trim of wall was peeling off, the paint to the frame of the bathroom door entrance was peeling, and a section of the center wall trim above Bed-A's nightstand was missing. 10. In Resident room [ROOM NUMBER], the three drawers of the TV stand dresser were broken. The unsampled resident stated that the drawers had been broken like that the entire time they had resided at the facility and they assumed the facility was aware because the condition of building was obvious. By Bed-B, the back wood of the TV dresser was coming off, the bottom of the dresser's trim was broken, and the floor around the dressers were soiled black. Underneath the AC unit, the trim was peeling off and the chair was stained with paint peeling. 11. In Resident room [ROOM NUMBER], the black trim to the right of the entrance was worn. 12. The wooden wall board across from the elevators were cracked with holes. On 5/8/25, from 10:46 AM to 10:58 AM, the surveyor toured the Third-floor nursing unit and observed the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	13. In Resident room [ROOM NUMBER], on the floor near the entrance, appeared to be soiled clothes in plastic bags and a bag full of waste/garbage on the floor. Bed-A's headboard was broken, the pillow had a brown stain on it, the ceiling tile above the bed was coming off track, and the TV stand dresser drawers were chipped. The trim to the outside bathroom door frame, the paint was peeling off and the toilet bowl was stained with brownish/green streaks. 14. At 10:50 AM, the surveyor observed the Housekeeper (HK #1) cleaning Resident room [ROOM NUMBER], that had plastic bags filled with clothing outside. HK #1 stated that the bags were on the floor in the inside of the room, and that she had moved them into the hallway to clean the floor. HK #1 reported that she cleaned the floors and bathrooms daily in each resident room, and that the maintenance staff cleaned the AC units. The surveyor observed inside the resident room, a hole behind the door and the TV stand dresser for Bed-A's bottom trim was broken. 15. In Resident room [ROOM NUMBER], the wallpaper was peeling off the wall to the left of the entrance and the outside bathroom door frame's paint was peeling. The wardrobe closet doors did not close. 16. In Resident room [ROOM NUMBER], the nightstand was peeling. On 5/8/25 at 10:59 AM, the surveyor interviewed the Environmental Service Director (ESD), who stated stated that the housekeeping staff cleaned every resident room and bathroom daily, which included the weekends. The ESD stated that the housekeeping staff cleaned inside the AC unit's vents, and the maintenance staff changed the AC filters. The ESD stated every Friday, staff should be taking off the AC unit's covers and cleaning the dust and debris inside. On 5/8/25 at 11:02 AM, the surveyor accompanied by the ESD toured the Second-floor nursing unit and the ESD confirmed the following concerns: In Resident room [ROOM NUMBER], the ESD identified the discoloration of the toilet bowl to be rust that did not come off. In Resident room [ROOM NUMBER], the ESD identified the discoloration of the toilet bowl to be rust, and he stated that if you scrubbed the rust off, it would leave a mark on the bowl. The surveyor asked how the porcelain toilet bowl rusted, and the ESD did not know how rust would get there. At 11:05 AM, the ESD acknowledged that Resident #1's AC unit was soiled with debris and should have been cleaned by the housekeeping staff. On 5/8/25 at 11:07 AM, the surveyor interviewed HK #2, who stated that she cleaned all the residents' rooms daily which included sweeping, mopping, and the toilets. On 5/8/25 at 11:10 AM, the surveyor observed in Resident room [ROOM NUMBER], that Bed-A's bedside table had peeling paint, their TV stand dresser's paint was peeling, and there was wallpaper missing from the walls. (continued on next page)

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	315454	A. Building B. Wing	05/08/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/8/25 at 11:15 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM), who stated she was aware the condition of the residents' furniture, and stated that she was informed in a morning meeting that the facility was getting new furniture. The LPN/UM stated that the facility used a computerized work order system [name redacted] to put in maintenance requests. The LPN/UM stated that a lot in the facility was broken because the residents broke it, because it was a behavioral unit. The LPN/UM stated she was aware of the missing paint and trims, and that the Maintenance Director (MD) was out of the facility on leave. On 5/8/25 at 11:17 AM, the surveyor interviewed the Maintenance Staff (MS), who stated that the facility used a computerized work order system [name redacted] to put in maintenance requests. The MS stated that he recently changed all the AC units' filters and vacuumed it. On 5/8/25 from 11:20 AM to 11:29 AM, the surveyor and MS toured the facility, and he acknowledged the following observations: In Resident room [ROOM NUMBER], the MS confirmed the paint along the frame of the bathroom door needed to be painted, and he stated he did not recall a work order put in. In Resident room [ROOM NUMBER], the MS confirmed the holes in the walls and the paint coming off in the bathroom. The MS stated that the facility was like this when he started working there, and that he conducted rounds and did repairs that he saw were needed. The MS stated he mainly put drawers back together, changed bed remotes, and ceiling tiles. In Resident room [ROOM NUMBER], the MS acknowledged the stained ceiling tile, and stated it should have been changed. The MS confirmed that Resident #1's drawer was missing, and that the resident's aide should have reported that. The MS stated that the debris in the resident's AC unit should have been cleaned by housekeeping, and he confirmed the door was coming off of Bed-A's nightstand. The surveyor asked the MS if it was a clean, homelike environment, and the MS stated how was when I got here. On 5/8/25 at 11:30 AM, the surveyor interviewed the Certified Nursing Aide (CNA #1), who stated that if anything was broken, she was supposed to put it in the computerized work order system [name redacted] for maintenance. CNA #1 stated she was aware of the broken furniture, but did not put it in the system for maintenance. On 5/8/25 at 11:32 AM, the surveyor interviewed the Assistant Director of Nursing (ADON), who stated that the facility was aware of the broken furniture and needed paint. The ADON stated that the work was to be done for the facility's plan of correction (POC) from the previous survey, but the work had not been completed. The ADON thought the work might have started on the first floor. On 5/8/25, from 11:34 AM to 11:41 AM, the surveyor toured the First-floor nursing unit and observed the following: 17. In Resident room [ROOM NUMBER], the outside wood of the door was coming off. (continued on next page)

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	315454	A. Building B. Wing	05/08/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	18. In the Shower Room (C-17), there was a rusted metal rack outside the shower, a hole in the shower curtain, a broken patched soap holder in the shower wall that was rough to touch, stained blue flower grips on the shower and tile floor that were soiled black and ripped, and missing grout in-between the tiles and shower. 19. At 11:41 AM, the surveyor asked CNA #2 and CNA #3 what the exposed metal piping that had a broken frame around it was at the entrance to Resident room [ROOM NUMBER]. CNA #3 stated it use to be a vent or something, and CNA #2 confirmed the condition should be reported to maintenance. On 5/8/25 at 11:50 AM, the surveyor reviewed the facility's previous statement of deficiencies and POC from their last survey dated 2/14/25. The facility was cited for multiple concerns regarding the residents' furniture, soiled floors, molding and baseboards coming off the wall, as well as the shower room, which it was determined that the facility failed to ensure a clean, homelike environment. The facility's POC with a completion date of 4/3/25, indicated that the facility was going to educate the ESD on the facility's policies on keeping the resident's areas clean and presentable, all resident rooms will have a full maintenance and housekeeping audit done monthly to ensure all aspects of the room are functioning properly, the first floor shower room will be checked and cleaned daily, as well as, the shower curtain was replaced. On 5/8/25 at 12:03 PM, the surveyor, accompanied by the Licensed Nursing Home Administrator (LNHA) toured the First-floor nursing unit, and the following was acknowledged: In Resident room [ROOM NUMBER], the LNHA stated that he was unsure what the broken unit with exposed metal piping was, and he stated that it must have recently broken off. The surveyor asked if it should look like that, and the LNHA responded cannot ask me that. In the Shower Room (C-17), the surveyor informed the LNHA of the concerns with the rusted metal rack, shower curtain, soap holder, flower grips, and missing grout, and stated that the facility was previously cited for that. The LNHA responded that the facility was only cited for the shower curtain that was replaced, and the surveyor pointed out that the shower curtain had a hole in it. The LNHA asked what was wrong with the flower grips (which were soiled black and ripped). The LNHA acknowledged the missing grout. In Resident room [ROOM NUMBER], the LNHA acknowledged that the outside of the door to the room was chipping and there were broken tiles in the hallway outside the Activity Office. The LNHA also acknowledged the condition of Resident room [ROOM NUMBER] and Resident room [ROOM NUMBER]'s room doors. On 5/8/25 at 12:09 PM, the surveyor, accompanied by the LNHA, toured the Second-floor nursing unit, and the following was acknowledged: In Resident room [ROOM NUMBER] and #234, the LNHA acknowledged the wallpaper should not be peeling. In Resident room [ROOM NUMBER], the LNHA confirmed the condition of the bathroom and furniture, and he stated that the facility had ordered all new furniture that should arrive within thirty days. (continued on next page)

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	315454	A. Building B. Wing	05/08/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveyor and LNHA also observed Resident Room #'s 229, 230, 231, 234, and Dayroom, and the LNHA confirmed the concerns. On 5/8/25 at 12:25 PM, the LNHA stated that he was aware of the environmental issues, and the facility was in the process of fixing it. The surveyor asked the LNHA if it was a clean, homelike environment, and the LNHA responded I hear you. On 5/8/25 at 12:27 PM, the surveyor, accompanied by the LNHA, toured the Third-Floor nursing unit, and the following was acknowledged: In Resident room [ROOM NUMBER], the surveyor asked what was in the plastic bags on the residents' floor, if it was soiled laundry or refuse, and the LNHA was unsure. In Resident room [ROOM NUMBER], the surveyor informed the LNHA of the identified concerns as well as the soiled bed sheets with the fly flying around it. The LNHA stated that no resident had hurt themselves on the broken furniture, and stated that maintenance did do rounds. The LNHA acknowledged the multiple holes in the residents' walls as well as, the wallpaper was peeling throughout the building. A review of the undated facility provided Quality of Life - Homelike Environment policy included that the residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible .the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a.) clean sanitary and orderly environment; c.) inviting colors and decor; d.) personalized furniture and room arrangements; e.) clean bed and bath linens that are in good condition . NJAC 8:39-4.1(a)11; 27.2(j); 31.2(e)

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	315454	A. Building B. Wing	05/08/2025

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ185836, NJ186066 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to ensure staff, as well as himself, implemented the facility's Quality of Life - Homelike Environment policy and procedures to ensure the safety and well-being of all residents by providing a safe, clean, comfortable, and homelike environment. This deficient practice was identified for 3 of 3 nursing units, and was evidenced by the following: Refer F 584 A review of the facility's undated Administrator Job Description included the purpose of your position is to direct day-to-day function of the Facility in accordance with current federal, state, and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality of care can be provided to our residents at all times. Delegation of Authority: As Administrator you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties . Duties and Responsibilities: plan, develop, organize, implement, evaluate, and direct the Facility's programs and activities in accordance with guidelines issued by the Regional Administrator. Develop and maintain written policies and procedures and professional standards of practice that govern the operations of the Facility .Ensure that all employees, residents, family members, visitors, and general public follow the Facility's established policies and procedures .Assist in developing plans of corrections for cited deficiencies. Ensure such plans incorporate timetables and methods of monitoring to ensure such deficiencies do not recur .Safety and Sanitation .Ensure that the building and grounds are maintained in good repair .Equipment and Supply Functions .Ensure that the Facility is maintained in a clean and safe manner for resident comfort and convenience by assuring that the necessary equipment and supplies are maintained to perform such duties and services . A review of the undated facility provided Quality of Life - Homelike Environment policy included that the residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible .the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a.) clean sanitary and orderly environment; c.) inviting colors and decor; d.) personalized furniture and room arrangements; e.) clean bed and bath linens that are in good condition . On 5/8/25 from 9:40 AM to 10:40 AM, the surveyor toured the Second-floor nursing unit and observed multiple resident rooms with wallpaper and paint peeling, furniture that was broken or paint peeling, door frames with paint peeling, chairs that were soiled and paint peeling, soiled floors, toilet bowls that were stained with a black/brown discoloration, grab bars (bars affixed to the wall for safety) next to toilets coming of the walls, holes in walls, missing trim, and discolored ceiling tiles. (continued on next page)

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	315454	A. Building B. Wing	05/08/2025

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/8/25 at 9:59 AM, the surveyor observed a blackish/brown stain around the inside of the toilet bowl of Resident room [ROOM NUMBER]. At that time, the surveyor asked the Licensed Practical Nurse (LPN #1) to accompany them into Resident room [ROOM NUMBER]'s bathroom, and the surveyor asked what that substance was. LPN #1 stated all toilets look like that, and that the housekeeping staff cleaned the toilets, but it did not come off. The surveyor asked if the facility was aware of the stain, and LPN #1 stated she would assume the facility was aware, and in her opinion, the facility did not think it was an issue. On 5/8/25 at 10:05 AM, Resident #1 reported and showed the surveyor that the bottom left drawer of their wardrobe closet was a fake drawer. Resident #1 pulled the drawer out and showed that the drawer had no bottom, it was just a frame. Resident #1 also stated that the left wardrobe closet door did not close. The surveyor asked if staff were aware, and Resident #1 stated that staff attempted to close it every time they walked by and it did not close. Resident #1 then showed the surveyor blackish colored stains on the floor between the three dressers, and stated that the room next to them had a water leak that came into their room, and the facility never cleaned it. Resident #1 also showed the surveyor their air conditioner unit (AC) that was soiled with dust, food debris, and a thumbtack. On 5/8/25 at 10:30 AM, in Resident room [ROOM NUMBER], the three drawers to the television (TV) dresser were broken. The unsampled resident stated that the drawers had been broken like that the entire time they had resided at the facility and they assumed the facility was aware because the condition of building was obvious. By Bed-B, the back wood of the TV dresser was coming off; the bottom of the dresser's trim was broken; and the floor around the dressers was soiled black. Underneath the AC unit, the trim was peeling off and the chair was stained with paint peeling. On 5/8/25, from 10:46 AM to 10:58 AM, the surveyor toured the Third-floor nursing unit and observed multiple resident rooms with peeling wallpaper and paint, furniture that was broken or paint peeling, door frames with paint peeling, toilet bowls that were stained with a black/brown discoloration, and soiled bed linen. On 5/8/25 at 10:59 AM, the surveyor interviewed the Environmental Service Director (ESD), who stated stated that the housekeeping staff cleaned every resident room and bathroom daily, which included the weekends. The ESD stated that the housekeeping staff cleaned inside the AC unit's vents, and the maintenance staff changed the AC filters. The ESD stated every Friday, staff should be taking off the AC unit's covers and cleaning the dust and debris inside. On 5/8/25 at 11:02 AM, the surveyor accompanied by the ESD toured the Second-floor nursing unit and the ESD confirmed the following concerns: In Resident room [ROOM NUMBER], the ESD identified the discoloration of the toilet bowl to be rust that did not come off. In Resident room [ROOM NUMBER], the ESD identified the discoloration of the toilet bowl to rust, and he stated that if you scrubbed the rust off, it would leave a mark on the bowl. The surveyor asked how the porcelain toilet bowl rusted, and the ESD did not know how rust would get there. On 5/8/25 at 11:05 AM, the ESD acknowledged that Resident #1's AC unit was soiled with debris and should have been cleaned by the housekeeping staff. (continued on next page)

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	05/08/2025

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Shore Gardens Rehabilitation and Nursing Center	231 Warner Street Toms River, NJ 08755

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/8/25 at 11:07 AM, the surveyor interviewed the Housekeeper (HK #2), who stated that she cleaned all the residents' rooms daily which included sweeping, mopping, and the toilets. On 5/8/25 at 11:15 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM), who stated she was aware the condition of the residents' furniture, and stated that she was informed in a morning meeting that the facility was getting new furniture. The LPN/UM stated that the facility used a computerized work order system [name redacted] to put in maintenance requests. The LPN/UM stated that a lot in the facility was broken because the residents broke it, because it was a behavioral unit. The LPN/UM stated she was aware of the missing paint and trims, and that the Maintenance Director (MD) was out of the facility on leave. On 5/8/25 at 11:17 AM, the surveyor interviewed the Maintenance Staff (MS), who stated that the facility used a computerized work order system [name redacted] to put in maintenance requests. The MS stated that he recently changed all the AC units' filters and vacuumed it. On 5/8/25 at 11:30 AM, the surveyor interviewed the Certified Nursing Aide (CNA #1), who stated that if anything was broken, she was supposed to put it in the computerized work order system [name redacted] for maintenance. CNA #1 stated she was aware of the broken furniture, but did not put it in the system for maintenance. On 5/8/25 at 11:32 AM, the surveyor interviewed the Assistant Director of Nursing (ADON), who stated that the facility was aware of the broken furniture and needed paint. The ADON stated that the work was to be done for the facility's plan of correction (POC) from the previous survey, but the work had not been completed. The ADON thought the work might have started on the first floor. On 5/8/25, from 11:34 AM to 11:41 AM, the surveyor toured the First-floor nursing unit and had multiple observations of broken resident doors and the Shower Room (C-17) had a rusted metal rack, shower curtain with a hole in it, a broken patched soap holder in the shower wall that was rough to touch, stained blue flower grips on the shower and tile floor that were soiled black and ripped, and missing grout in-between the tiles and shower. On 5/8/25 at 11:50 AM, the surveyor reviewed the facility's previous statement of deficiencies and POC from their last survey dated 2/14/25. The facility was cited for multiple concerns regarding the residents' furniture, soiled floors, molding and baseboards coming off the wall, as well as the shower room, which it was determined that the facility failed to ensure a clean, homelike environment. The facility's POC with a completion date of 4/3/25, indicated that the facility was going to educated the ESD on the facility's policies on keeping the resident's areas clean and presentable, all resident rooms will have a full maintenance and housekeeping audit done monthly to ensure all aspects of the room are functioning properly, the first floor shower room will be checked and cleaned daily, as well as, the shower curtain was replaced. On 5/8/25 at 12:03 PM, the surveyor, accompanied by the Licensed Nursing Home Administrator (LNHA) toured the First-floor nursing unit, and the following was acknowledged the surveyor's findings. (continued on next page)

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	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shore Gardens Rehabilitation and Nursing Center	231 Warner Street Toms River, NJ 08755

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/8/25 at 12:07 PM, in the Shower Room (C-17), the surveyor informed the LNHA on the concerns with the rusted metal rack, shower curtain, soap holder, the soiled and ripped flower grips, and missing grout, and stated that the facility was previously cited for that. The LNHA responded that the facility was only cited for the shower curtain that was replaced, and the surveyor pointed out that the shower curtain had a hole in it. The LNHA asked what was wrong with the flower grips (which were soiled black and ripped). The LNHA acknowledged the missing grout. On 5/8/25 at 12:09 PM, the surveyor, accompanied by the LNHA, toured the Second-floor nursing unit, and the LNHA acknowledged the surveyor's concerns. On 5/8/25 at 12:25 PM, the LNHA stated that he was aware of the environmental issues, and the facility was in the process of fixing it. The surveyor asked the LNHA if it was a clean, homelike environment, and the LNHA responded I hear you. On 5/8/25 at 12:27 PM, the surveyor, accompanied by the LNHA, toured the Third-Floor nursing unit, and the LNHA acknowledged the surveyor's concerns. A review of the computerized work order system [name redacted] for maintenance Work Orders report from 4/1/25 to present, did not indicate the day the work request was made, and it did not include all of the surveyor's identified concerns. The work order did include several resident rooms needed furniture repaired which included: Resident room [ROOM NUMBER], #218, #306, #203, #314, and #233. On 5/8/25 at 1:37 PM, the LNHA in the presence of the Regional LNHA provided the surveyor with a quote for furniture. The LNHA stated that the facility was aware that the furniture all needed to be replaced and that was why the facility got a quote. The Regional LNHA confirmed that the facility needs a lot of work. When the surveyor asked the LNHA what his responsibilities and role at the facility was, the LNHA responded that he was responsible for the facility which included; staff, residents, and the condition of the facility. The surveyor reviewed the Quote dated 3/11/25, with an invoice #250895, which included the cost of the furniture, with the vendor name listed as the facility and to ship to the facility. There was no evidence that the furniture was actually purchased. The surveyor reviewed a copy of a check provided by the LNHA, that he indicated was a deposit for the furniture payment dated 3/13/25. There was no evidence provided that this check was provided to the vendor. NJAC 8:39-4.1(a)11; 9.2(a); 9.3(a); 27.2(j); 31.2(e)