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	08/20/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** NJ# 184886Based on interview and review of pertinent facility documentation on 8/19/25 and 8/20/25, it was determined that the facility failed to develop and implement an effective discharge (d/c) planning process that focused on the resident's discharge goals to return to the community. The deficient practice was identified for 1 of 3 residents (Resident # 6), reviewed for community discharge. The deficient practice was evidenced by the following:During a tour on 8/20/25 at 9:30AM, Resident #6 was observed sitting up in bed watching television.On 8/20/25 at 9:40AM, Surveyor interviewed Resident #6 in the presence of their family member. Resident #6 stated that on their day of discharge, he/she was told that an Uber was going to pick them up and transport them to a local hotel. Resident #6 stated that the Uber (a type of transportation service) dropped them off in the middle of the parking lot. He/she further stated, they walked into the hotel to check, and he/she was told they needed to pay $50 in ordered to check-in. Resident #6 explained they did not have any money, so they left the building and went outside, where they fell and ultimately had to call 911. Resident #6 further stated that the facility was called and informed of the fall, and the resident was re-admitted to the facility the next day. Resident #6 denied asking their Social Worker to leave the facility or receiving prior notice of the 3/26/25 discharge.A review of Resident #6's admission Record (AR) (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to repeated falls and muscle weakness.A review of Resident #6's Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that Resident #6 was cognitively intact. The MDS reflected Resident #6 was independent with activities of daily living (ADLs), supervision/touch assist with transfers and ambulation.A review of a Social Services Note (SSN) written on 11/26/24 at 1:44PM, revealed the Social Worker (SW) informed Resident #6's family member of a Notice of Medicare Non-Coverage (NOMNC) letter, and informed them of the process to appeal.A Review of an SSN written on 11/29/24 at 2:11PM, revealed the SW informed Resident #6's family member of the Detailed Explanation of Non-Coverage (DENC) letter that was sent by the insurance company.A review of the Occupational Therapy Discharge Summary (OTDS) signed on 1/3/2025 at 7:35 PM, stated, Discharge recommendations: D/c secondary to change in payer source. Patient will be re-evaluated under new payer source and new goals set as appropriate. Assistance with IADLs (Instrumental Activities of Daily Living), Assistive device for safe functional mobility, elevated toilet/3 in one commode, home exercise program, home health services, long handled sponge, safety equipment: monoxide detector, smoke alarm, shower chair with back, and 24-hour care.A review of Physician Orders, reflected on order for discharge on [DATE].A review of a SSN written 3/26/25 at 1:23PM, stated, SW spoke with Resident in regards to discharge plan.A review of the Interdisciplinary Discharge Summary and Guide dated 3/26/25 at 2:17PM, reflected a referral for Visiting Nursing services. There was no documentation if Durable Medical Equipment (DME) was ordered, or any other community referrals were made.A review of SSN written 3/26/25 at 2:24PM, stated, [Resident #6] was discharged to the community. At the time of discharge to the community the resident was given a full reconciled medication list, and instructions to contact his/her PCP (Primary Care Physician) for follow-up. Resident was given transport to the community with all of his/her belongings.There was no other documentation that was provided regarding the plan for Resident #6's 3/26/25 discharge to the community.A review of a Progress Note (PN) written by the Registered Nurse (RN) Supervisor on 3/27/25 at 10:11PM, reflected Resident #6 was back at the facility after going to a local hospital due to a fall at home.During an interview with the Assistant Director of Nursing (ADON) on 8/20/25 at 10:35AM, she revealed that she was not part of Resident #6's discharge planning and was unaware of Resident #6's discharge until the day that the discharge occurred. She further stated that discharges are usually discussed at Utilization Review (UR) Meetings but does not recall if Resident #6's discharge was discussed. She further explained the Administrator, Director of Nursing (DON), ADON, Director of Social Services (DSS), MDS Coordinator, Director of Rehab (DOR), and Unit Managers, attend the UR meetings.During an interview with the DSS on 8/20/25 at 10:55AM, stated that the SW who handled the d/c planning for Resident #6 no longer works at the facility. During the interview she revealed Resident #6 was to be short-term, but did not have any place to go after discharge. The DSS explained the previous SW setup the community discharge at the resident's request to leave. She further stated that Resident #6 was discharged and transported in an Uber to a hotel that was paid for a couple of nights, but unsure of what