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	01/05/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Complaint #: 374226Based on interviews, review of medical records, and review of other pertinent facility documents on 12/30/2025, it was determined that the facility failed to ensure that residents received care and services necessary to attain or maintain the highest practicable physical well-being, in accordance with professional standards of practice, by failing to properly assess, acknowledge pain, monitor, notify provider, and implement appropriate interventions for an identified unwitnessed fall and femur fracture.This deficient practice was identified for 1 of 3 residents reviewed (Resident #1), as evidenced by the following:Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. According to the admission Record (AR), Resident #1 was admitted with diagnoses that included but were not limited to: dementia.According to the Minimum Data Set (MDS), an assessment tool dated 02/23/25, Resident #1 had a Brief Interview for Mental Status (BIMS) score that was not completed. Section C0100 reveals code 0 0. No (resident is rarely/never understood) - Skip to and complete staff assessment that reveals resident #1 has long and short-term memory problems.A review of Resident #1's Progress Note (PN) dated 4/3/25 at 3:36 P.M., reveals Late entry 04/02/2025 At around 8pm, this writer [License Practical Nurse #1] was called by one of the residents. I observed [Resident #1] lying/sitting on the floor inside [their] room, upper body leaning halfway on a regular chair. [Resident #1] cannot give accurate statement at this time. Assessment done with no visible injury noted; however c/o [complains of] pain on [their] left leg; no swelling, no redness or any signs of trauma noted. Resident offered pain medications but refused x 3. [Resident #1] assisted to bed; no s/s of acute distress noted. MD [Medical Doctor] and NOK [next of kin] notified. There is no PN identified from 4/2/25 after fall noted.During an interview on 12/30/2025 at 1:37 P.M., with LPN #1, the LPN stated they found Resident #1 on the floor on 4/2/25 and Resident #1 complained of leg pain and was able to make a couple of steps to the bed. LPN #1 states that Resident #1 was offered pain medication and Resident #1 refused it. LPN #1 further states that she did not go back and check on the resident since he did not require pain medication, and she needed to complete a medication pass to the other residents. LPN #1 states she called and left a message with the physician and called the family but did not tell the physician Resident #1 was complaining of pain because [Resident #1] always complains of pain to the legs from arthritis.A review of Resident #1's Neurological Flow Sheet from the time period beginning 8:15 P.M., on 4/2/25 and ending on 11:00 A.M., on 4/3/25. Resident #1's level of consciousness is not completed from 4/2/25 at 10:30 P.M., through 4/3/25 at 3:00 A.M., with the notation of sleep. Resident #1's Movement is not completed from 4/3/25 at 12:00 A.M., until (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
	315454	A. Building B. Wing	01/05/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	4/3/35 at 7:00 A.M., with the notation of Refused and 3:00 A.M., slot being blank. The section labeled Initials: is left blank on:4/2/25 at 8:45 P.M.4/2/25 at 9:00 P.M.4/2/25 at 9:30 P.M.4/2/25 at 10:00 P.M.4/2/25 at 10:30 P.M.4/2/25 at 11:00 P.M.4/3/25 at 1:00 A.M.4/3/25 at 2:00 A.M.A review of Resident #1's Care Plan (CP) with a start date of 04/3/25, reveals Unwitnessed fall, MD family aware, assessment completed sent to [Hospital] for eval of left hip pain. Further review of CP with a start date of 4/9/25, reveals bed to be in lowest position to provide safety.Frequent rounding.PT/OT evaluation.During an interview on 12/30/2025 at 2:06 P.M., with the Director of Nursing (DON), the DON states for Resident #1 the desired outcome for the CP interventions were not met since Resident #1 continued to fall and no, I guess they [interventions] were not adequate if [they] kept falling. The DON further states after an injury the nurse should monitor a resident according to the neurological flow sheet and complete pain monitoring for 48 hours after an incident. The DON states no blanks should be present on the neurological flow sheet. The DON states the LPN should have spoken to the provider explaining that Resident #1 was in pain, not left a message. When asked if there is a PN from the 3 P.M. to 11 P.M. or 11 P.M. to 7 A.M. from the fall, the DON states I don't see one here.A review of the facility's policy titled Falls and Fall Risk, Managing with a revised date of December 2007, reveals under Prioritizing Approaches to Managing Falls and Fall Risk 4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.A review of the facility's policy titled Assessing Falls and Their Causes with a revised date of October 2010, reveals under Steps in the Procedure 4. When a fall results in a significant injury or condition change, nursing staff will notify the practitioner immediately by phone . 5. Nursing staff will observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall, and will document findings in the medical record. 6. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. It will note the presence or absence of significant findings. The policy further states under Performing a Post-Fall Evaluation: 1. After a first fall, a nurse and/or physical therapist will watch the resident attempt to rise from a chair without using his or her arms, walk several paces, and return to sitting, and will document the results of the effort.A review of the facility's policy titled Care Plans - Comprehensive with a revised date of September 2010, reveals under Policy Interpretation and Implementation . 9. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: 1 . b. When the desired outcome is not met;A review of the facility's policy titled Accidents and Incidents - Investigation and Reporting with a revised date of February 2014, reveals under Policy Interpretation and Implementation 1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident.