

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER Shore Gardens Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Complaint #3007960Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident (Resident #144), who was dependent on staff for transfers, was safely and properly transferred with two staff members via a mechanical lift. On 5/4/26, the resident was transferred by one staff member from their bed to a shower chair, which resulted in the resident sustaining a left upper extremity humeral fracture (a fracture of the left upper arm). This deficient practice was identified for 1 of 6 residents (Resident #144) reviewed for accidents and was evidenced by the following: On 6/23/26 at 9:00 AM, the surveyor requested from the Licensed Nursing Home Administrator (LHNA) a copy of the Facility Reportable Event (FRE) submitted to the New Jersey Department of Health (NJDOH) for Resident #144. On 6/23/26 at 9:00 AM, the surveyor reviewed the FRE provided by the LHNA. The report documented that on 5/4/26 at 11:15 AM, the Certified Nursing Assistant (CNA #11) was assisting Resident #144 with a shower and observed that the resident's left upper arm appeared deformed. The finding was immediately reported to the Director of Nursing (DON), and the resident was promptly assessed by the Nurse Practitioner (NP). The NP noted an indentation of the left upper arm and abnormal movement originating from the mid-humerus (upper arm bone). The NP ordered Resident #144 to be sent to the Emergency Department (ED) for further evaluation. CNA #11 was immediately suspended pending outcome of the facilities investigation. The Resident Representative, DOH, and Ombudsman were notified. A review of the Progress Notes dated 5/5/26 at 11:07 AM, authored by the DON, revealed that the hospital indicated that Resident #144 was diagnosed with an acute fracture of the left distal humerus. The surveyor reviewed Resident #144's closed medical record which revealed the following: A review of the admission Face Sheet revealed that Resident #144 was admitted to the facility with the diagnoses which included but were not limited to; dementia, diabetes mellitus, metabolic encephalopathy (impaired brain function), and peripheral vascular disease (narrowing of the blood vessels). A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated 4/8/26, revealed that the resident had short and long-term memory problems with severely impaired decision making. A further review under Section GG-Functional Abilities, revealed that the resident was dependent on tub/shower transfer meaning the helper does all the effort, resident does none of the effort to complete activity, or the assistance of two or more helpers was required for the resident to complete the activity. A review of the Activities of Daily Living (ADL) change of status forms dated 11/10/25 and 4/20/26, both indicated that the resident was dependent on sitting to stand, chair/bed-to-chair transfer, toilet transfer and tub/shower transfer. A review of the Occupational Therapy treatment plan dated 6/19/25 to 7/18/25, indicated that Resident #144 was to be mechanically lifted due to safety concerns. A review of the Occupational Therapy treatment plan dated 11/11/2025 to 11/26/25, indicated that Resident #144 was dependent and was transferred via (by way of) a mechanical lift. A review of the Individualized Comprehensive Care Plan (ICCP) did not include a focus area for functional ability performance and there were no interventions implemented on the type of assistance the resident required for transfers prior to 5/4/26. A review of the Progress Notes dated 5/4/26, indicated that at 10:40 AM, CNA #11 notified the nurse that the resident's left (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
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F 0689 Level of Harm - Actual harm Residents Affected - Few	arm was swollen. Upon inspection, the nurse documented that the left arm was swollen, warm and firm to touch. The resident was grimacing during gentle tactile inspection and pulses were present. The nurse notified the NP and DON. The nurse then administered the resident Tylenol 650 milligrams (mg) for pain and discomfort. The resident was then sent to the ED for further evaluation. A review of the radiology imaging report from the hospital, dated 5/4/2026 at 1:54 PM, revealed the resident sustained an acute comminuted displaced fracture of the distal left humerus. A review of the FRE conclusion provided by the facility, indicated that Resident #144 sustained an injury during a transfer from the bed to shower chair that required necessary revisions to the functional mobility care plan, transfer status and possible need for a mechanical lift. On 6/23/26 at 12:36 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1), who stated that Resident #144 had limited mobility and a contracted (refers to the shortening or tightening of a muscle or muscle fiber, which can occur in skeletal, smooth, or cardiac muscle, and is essential for movement) upper extremity. LPN/UM #1 explained that the resident was dependent on staff for ADLs and required a two-person assistance for transfers. LPN/UM #1 reported that CNA #11 was assisting Resident #144 with a shower, when the CNA observed that the resident's arm was swollen and painful. LPM/UM #1 stated that she was not involved in the subsequent investigation, and the DON and Assistant Director of Nursing/Infection Preventionist (ADON/IP) conducted the investigation. LPN/UM #1 further stated that she was not informed of the investigation's outcome. On 6/23/26 at 12:51 PM, the surveyor interviewed the ADON/IP, who stated that she participated in the investigation regarding Resident #144's left humerus. The ADON/IP reported that CNA #11 observed a deformity of the resident's left arm and immediately reported the finding. The ADON/IP stated that the investigation determined that CNA #11 had transferred Resident #144 independently by lifting the resident under the arms, which CNA #11 had demonstrated the transfer technique to the DON, Regional DON, and herself. The ADON/IP was unable to recall the required number of staff needed to safely transfer Resident #144, but stated she would obtain that information for the surveyor. On 6/23/26 at 2:24 PM, the surveyor interviewed the DON, who confirmed that Resident #144 was dependent on ADL care and required a two-person assistance for transfers. The DON acknowledged that the resident's ICCP did not include the requirement for a two-person mechanical lift transfer. The DON stated that this omission resulted from a communication error between the rehabilitation therapy department and the nursing department. The DON further stated that CNA #11 should have obtained assistance from another staff member before transferring Resident #144 and characterized the incident as a learning experience. On 6/24/26 at 10:18 AM, the surveyor interviewed LPN #2, who had provided care for Resident #144, and stated that the resident required total care and a two-person assist for all transfers to ensure the safety of both the resident and staff during transfers between bed and chair and vice versa. On 6/24/26 at 10:23 AM, the surveyor interviewed CNA #11, who stated that Resident #144 was dependent on staff for all ADLs and could not walk or feed themselves. CNA #11 noted that while the resident sometimes needed a two-person transfer to get out of bed, they were small in stature, allowing her to lift them under the arms and pivot them into a chair. CNA #11 stated she was unaware that the resident required a mechanical lift, noting there were no such instructions in the EMR and that she typically checked the ICCP to determine a resident's specific care requirements. On 6/24/26 at 10:39 AM, the surveyor interviewed the Director of Rehabilitation Therapy (DOR), who stated that Resident #144 required a two-person assistance for transfers. The DOR clarified that when a non-ambulatory resident was assessed by therapy as requiring a two-person assistance, they must be lifted and transferred via a mechanical lift to ensure the safety of both the resident and the staff. On 6/24/26 at 10:57 AM, the surveyor interviewed the MDS Coordinator, who explained that when a resident was assessed as dependent it meant that the resident required two or more staff members to assist with the task. The MDS Coordinator stated that Resident #144 required at least two or more staff members to assist with all transfers, meaning a mechanical lift should have been utilized. The MDS Coordinator confirmed that instructions specifying the need for a mechanical lift (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	should have been included in Resident #144's care profile and ICCP. On 6/25/26 at 9:56 AM the surveyor interviewed LPN/UM #1, who confirmed that Resident #144 was dependent for ADLs and transfers, defining dependent care in this context as requiring a two-person mechanical lift. LPN/UM #1 explained that the CNAs review the resident care profile in the EMR to determine necessary care levels. However, LPN/UM #1 confirmed that Resident #144's mechanical transfer requirements were missing from both the care plan and the resident's profile. LPN/UM #1 emphasized that documenting this information was critical to ensuring resident safety during transfers. A review of the facility policy dated 2/15/26, and titled Visual Electronic Medical Record Accessing a Resident Care Profile in Visual EMR, indicated that the purpose of the policy was to establish standardized, secure and compliant procedures for accessing a resident's Care Profile within the Visual EMR system. This ensures resident privacy, supports accurate documentation, and maintains compliance with HIPAA [Health Insurance Portability and Accountability Act] and facility confidentiality standards. The policy indicated that all entries must be accurate, timely. A review of the facility policy dated 5/14/25, and titled Person Centered Care Planning, indicated that the facility was responsible to develop, implement, maintain and update an individualized interdisciplinary, person-centered plan of care for every resident that supports the resident's highest practicable physical, mental and psychosocial well-being, resident's preferences and choices. The care plan findings would be based on assessment findings and resident needs. A review of the facility policy dated 2/2026, and titled Mechanical Lift, indicated that it was the policy to ensure the safe transfer and repositioning of residents requiring the use of a mechanical lift. Mechanical lifts shall be used in accordance with the residents' assessed needs, the individualized care plan, manufacturer's instructions, and current standards of practice to prevent injury to residents and staff. Safe use of mechanical lifts is an important component of accident prevention under CMS regulations. Purpose: Promote resident safety and comfort during transfers. Reduce the risk of falls, skin injury, and musculoskeletal injuries. Protect staff from lifting-related injuries. Ensure consistent, safe transfer practices. Staff Required: Two trained staff members shall be present during all mechanical lift transfers. One staff member operates the lift while the second guides and protects the resident throughout the transfer. This is considered the best practice and is commonly expected by surveyors to reduce transfer-related injuries. A review of the facility policy dated 5/2022, and titled Incidents and Accidents, indicated that the unit manager and staff nurse must ensure that an appropriate plan of care was implemented to prevent further reoccurrence to prevent further similar incidents or accidents from occurring. NJAC 8:39-27.1(a)		