STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315394	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT THE SHORES	**2201 BAY AVENUE , OCEAN CITY, New Jersey, 08226**

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined the facility failed to conduct a new NJ Exec Order 26.4b1 [redacted] assessment after a resident received a new NJ Exec Order [redacted] diagnosis. This deficient practice was identified in 1 of 1 resident reviewed for NJ Exec Order (Resident #4) and was evidenced by the following: On 08/26/2025 at 7:06 PM, during the initial tour of the facility Resident #4 was in the room in bed. On 8/27/25 at 11:26 AM, the surveyor reviewed the medical Record for Resident #4. A review of the Admission Record face sheet (an admission summary) reflected the resident was initially admitted to the facility with diagnoses which included but not limited to failure to NJ Exec Order 26.4b1 [redacted].	F0644	1. Corrective Action for Resident #4 A NJ Exec Order 26.4b1 screening was initiated and completed by the Social Worker for Resident #4 The resident's updated diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 were incorporated into the care plan and communicated to the interdisciplinary team. A referral for NJ Exec Order 26.4b1 evaluation was submitted to the NJ NJ Exec Order program 2. Identification of Other Residents Potentially Affected All residents may be at risk for this practice. The MDS Coordinator performed a facility-wide audit of all current residents to identify any individuals with newly diagnosed or previously undocumented serious mental illness, intellectual disability, or related conditions. Any residents identified through this audit were reviewed for PASRR Level I accuracy and referred to the Social Worker for Level II evaluation as appropriate. 3. Systemic Changes to Prevent Recurrence A PASRR business practice was developed and implemented, outlining: PASRR Level I screening requirements upon admission and during significant change in status. Criteria for referral to Level II evaluation. Integration of PASRR findings into care planning and transitions of care.	09/26/2025

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315394	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT THE SHORES	2201 BAY AVENUE , OCEAN CITY, New Jersey, 08226

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F0644 SS = D	Continued from page 1 A review of Resident #4's NJ Exec Order 26.4b1 in the Electronic Medical Record (EMR) dated NJ Exec Order 2 showed that section one of the NJ Exec Order asked if the resident had a NJ Exec Order 26.4b1 was marked as “no”. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 2 reflected the resident had a Brief Interview of Mental Status (BIMS) score of NJ E out of 15, meaning the resident was NJ Exec Order 26.4b1. A review of section I of the MDS titled active diagnoses revealed the resident had a diagnosis of NJ Exec Order 26.4b1 . On 8/28/25 at 10:15 AM, the surveyor interviewed the US FOIA (b)(6)) regarding the NJ Exec Order 26.4b1 being marked as no for NJ Exec Order 26.4b1 and the US FOIA stated it should be reviewed on admission to the facility. On 8/29/25 at 10:00 AM, the surveyor requested a copy of the NJ Exec Order policy from the US FOIA and the US FOIA told the surveyor the facility did not have a NJ Exec Order policy. NJAC 8:39-27.1(a)	F0644	Continued from page 1 The business practice was reviewed and approved by the Quality Assurance and Performance Improvement (QAPI) Committee. Admissions and Social Services were educated by the Administrator and DON; the MDS staff was re-educated by the Manager of Reimbursement & Medical Records on PASRR requirements, including coordination with assessments and documentation protocols. 4. Monitoring and Quality Assurance The Director of Nursing or designee will audit 100% of PASRR documentation for all new admissions and significant change in status assessments for a period of 4 weeks following implementation. Thereafter, a 20% random sample of applicable assessments will be audited monthly for the remainder of the quarter to ensure sustained compliance. Audit findings will be reviewed during monthly QAPI meetings to identify trends, reinforce accountability, and guide any necessary interventions. Results will be reported to the QA Committee during the Quarterly QA meeting to ensure sustained compliance	
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders.	F0655	1. Corrective Action for Resident #45 Resident #45’s care plan was immediately updated on NJ Exec Order 2 to include all active diagnoses and medications, including NJ Exec Order 26.4b1). US FOIA (b)(6) was re-educated by the RN Staff Educator on the importance of including critical medications and diagnoses in the baseline care plan within 48 hours of admission. 2. Identification of Other Residents at Risk All newly admitted residents may be at risk for this practice. A facility-wide audit was conducted by the DON/designee on 8/29/25 of all residents admitted within the past 30 days to ensure baseline care plans were completed within 48 hours and included all essential information.	09/26/2025

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F0655 SS = D	Continued from page 2 (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on Interview, record review, and review of other facility documentation, it was determined that the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident. The deficient practice was identified for 1 of 1 resident (Resident #45) investigated for Unnecessary Medications and was evidenced by the following: A review of Resident #45's Admission Record reveale diagnoses of but not limited to; NJ Exec Order 26.4b1 [redacted]	F0655	Continued from page 2 No other residents were found to be missing critical medication documentation in their baseline care plans. 3. Systemic Changes to Prevent Recurrence The Admitting Nurse and Unit Manager/designee will jointly review all new baseline care plans within 24 hours of creation. A Baseline Care Plan Auditing Process was implemented on 9/1/25 to ensure all new admissions have a complete care plan within 48 hours, including medications such as anticoagulants, antibiotics, and high-risk treatments. Licensed Nurses and IDT Team were re-educated by the RN Staff Educator on baseline care plan requirements during an in-service held on 9/2/25, with attendance documented. 4. Monitoring and Quality Assurance The Director of Nursing or designee will audit 100% of resident charts to ensure Baseline Care Plans were completed for new admissions within 48 hours for a period of four weeks following implementation. Thereafter, a 20% random sample of Baseline Care Plans will be audited monthly for the remainder of the quarter to ensure sustained compliance. Audit findings will be reviewed during monthly QAPI meetings to identify trends, reinforce accountability, and guide any necessary interventions. Results will be reported to the QA Committee during the Quarterly QA meeting to ensure sustained compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315394	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

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F0655 SS = D	Continued from page 3 NJ Exec Order 26.4b1). A review of Resident #45's Physician Orders (PO) dated NJ Exec Ord included: NJ Exec Order 26.4b1), give 1 tablet by mouth two times a day for NJ Exec Order 26.4b1) that prevents NJ Exec O from NJ Exec Order reducing the risk of NJ Exec Order 26.4b1 in the NJ Exec Order 2 NJ Exec Or or NJ Exec Or A review of Resident #45's Individual Comprehensive Care Plan (ICCP) revealed that there was only one care plan focus since the resident was admitted to the facility. The ICCP focus was dated NJ Exec Order and revealed that Resident #45 was at risk for NJ Exec Order 26.4b1 A review of Resident #45's "Admission 5 Day Minimum Data Set" (MDS), an assessment tool used to facilitate the management of care dated NJ Exec Order, included under section 'NJ E Medications, that Resident #45 was on an NJ Exec Order 26.4b1). On 8/28/25 at 10:35 AM, during an interview with the Surveyor, Register Nurse/Unit Manager (RN/UM #1) of the NJ Exec Order 26.4b1 Unit, replied, that the baseline care plan time frame is within 24 hours and should include interventions related to the diagnosis such as NJ Exec O NJ Exec issues, and most important things going on. RN/UM #1 agreed that NJ Exec Order 26.4b and NJ Exec Order 26.4b1 should be included in the baseline care plan within the first 24 hours. At that time the RN/UM #1 reviewed the resident's ICCP in the presence of the surveyor and RN/UM #1 stated that she did not see that Resident #45's ICCP included NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 . RN/UM #1 stated, yes, an NJ Exec Order 26.4b1 should be in the ICCP, I'm going to fix it right now. On 8/28/25 at 12:10 PM, during an interview with Administration in the presence of the survey team, the US FOIA (b)(6) stated that the time frame for a baseline care plan is 16 hours with a window of 48 hours and that an NJ Exec Order 26.4b1 should be included. On 8/28/25 at 12:00 PM, the surveyor reviewed the facility's policy titled, "Care Plan (RS-1)" with a revised date of 8/8/25 that included; "The Baseline Care Plan is to be completed upon admission and should include minimal instructions and information needed to provide effective and person-centered care of the resident…After completing the admission nursing evaluation, nursing will use the information available to develop the Baseline Care Plan within 16 hours of admission and will be reviewed with the	F0655		

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F0655 SS = D	Continued from page 4 resident/representative within 48 hours of admission with the Interdisciplinary Team (IDT) Care Conference." 8:39-11.2(d)	F0655		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set	F0656	1. Corrective Action for Resident #34 Resident #34's care plan was updated on 8/28/2025 to include: Focus area: NJ Exec Order 26.4b1 . Goals: NJ Exec Order 26.4b1 , prevent infection, NJ Exec Order 26.4b1 . Interventions: Daily NJ Exec Order 2 care, monitor for signs of NJ Exec Order 26 NJ Exec Order 26.4b1 , document NJ Ex Order 2 and notify MD of any complications. 2. Identification of Other Residents: All residents with indwelling catheters may be at risk for this practice. The DON conducted a facility-wide audit on 8/28/2025 to identify all residents with indwelling urinary catheters. Care plans were reviewed for all identified residents No other residents were found to be missing care plan for urinary indwelling catheter 3. Systemic Changes Policy Review: The DON reviewed the facility's care plan policy and confirmed it was comprehensive and clear in its direction. Staff Education: The RN Nurse Educator/designee educated all licensed nurses and interdisciplinary team members on 8/28/2025 regarding: Comprehensive care planning requirements. Inclusion of urinary indwelling catheters in care	09/26/2025

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UNITED METHODIST COMMUNITIES AT THE SHORES	**2201 BAY AVENUE , OCEAN CITY, New Jersey, 08226**

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F0656 SS = D	Continued from page 5 forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that the facility failed to develop and implement a care plan that meets the medical needs identified on the comprehensive assessment care for 1 on 15 residents reviewed for comprehensive care plans related to an NJ Exec Order 26.4b1 (Resident #34.) This deficient practice was evidenced by the following: A review of Resident # 34's admissions record revealed that, Resident # 34 was admitted with but not limited to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. A review of the Resident #34's admission Minimum Data Set (MDS) dated NJ Exec Order 26.4b1 revealed under section NJ that the resident had an NJ Exec Order 26.4b1. A review of the current Care Plan (CP) for Resident #34 did not include documentation of a CP focus area or interventions for the care of NJ Exec Order 26.4b1. During an interview on 08/28/2025 at 09:13 AM with the surveyor the US FOIA (b)(6) said that care plans are reviewed monthly and updated as need if the residents need change. The US FO also said that residents with NJ Exec Order 26.4b1 should have focus and interventions in place on a care plan. When asked if Resident #34 was care planned for the NJ Exec Order 26.4b the US FO stated "No NJ E is not, but NJ E will be." During an interview on 08/25/2025 at 12:12 PM with the surveyor the US FOIA (b)(6) said that residents with NJ Exec Order 26.4b1 should have focus and interventions in place on a care plan. A review of a facility provided policy revised on 08/08/2025 titles, "Care Plan" revealed under, "Procedure" that, "13. The interdisciplinary Care Plan Team will develop the care plan in coordination with the attending physicians plan of medical care. The Care plan is individualized and addresses the resident's	F0656	Continued from page 5 plans. Facility policy on care planning and documentation.Nurse management and MDS coordinators will: Audit all new admissions within 48 hours. Ensure newly implemented urinary catheters are updated in the care plan at the time of implementation. Include catheter care in the quarterly review process to ensure ongoing accuracy and compliance. 4. Monitoring and Quality Assurance The Director of Nursing or designee will conduct weekly audits x 4 weeks, then monthly for 2 months. Audit findings will be reviewed during monthly QAPI meetings to identify trends, reinforce accountability, and guide any necessary interventions. Results will be reported to the QA Committee during the Quarterly QA meeting to ensure sustained compliance	

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F0656 SS = D	Continued from page 6 medical, nutritional, psychological, physical, functional, social, educational and spiritual needs and the severity of the resident's condition..." NJAC 8:39-27.1(a)	F0656		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that an [redacted] was secured in a	F0690	1. Corrective Action for Resident Affected (Resident #34): On [redacted], the [redacted] for Resident #34 was immediately removed from contact with the floor and properly secured to the bed frame using a [redacted]. The resident was assessed for signs and symptoms of [redacted]; [redacted] were identified. The [redacted] & CNA staff responsible were re-educated by the RN Staff Educator on proper [redacted] and infection prevention protocols. 2. Identification of Other Residents at Risk: Any resident with indwelling catheters may be at risk for this practice. A full audit of all residents with indwelling urinary catheters was conducted by the DON/designee on 08/27/2025. No other residents were found to have catheter bags improperly positioned. 3. Systemic Changes to Prevent Recurrence: The facility's Foley Catheter Care and Maintenance Policy was reviewed by the DON and includes clear language on securing drainage bags and preventing floor contact. The RN Staff Educator provided licensed nursing staff and certified nursing assistants re-education on catheter care, infection prevention, and proper securing of drainage bags.	09/26/2025

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F0690 SS = D	Continued from page 7 manner to prevent contamination for 1 of 2 resident reviewed for a NJ Exec Order 26.4b1, (Resident #34). The deficient practice was evidenced by the following: During the initial tour of the unit on 08/26/2025 at 06:54 PM, Resident #34 was in bed with a NJ Exec Order 26.4b1 in contact with the floor, with NJ Exec Orde intact. It was not secured to the bed frame. A review of Resident # 34's admissions record revealed that, Resident # 34 was admitted with but not limited to NJ Exec Order 26.4b1 . A review of the Resident #34's admission Minimum Data Set (MDS) dated NJ Exec Order 26.4b1 revealed under section NJ that the resident had an NJ Exec Order 26.4b1. During an interview on 08/28/2025 at 09:13 AM with the surveyor, the US FOIA (b)(6)) said, NJ Exec Order 26.4b1 should be hanging on the side of the bed frame, not touching the floor and in a NJ Exec Order 26.4b1 to prevent contamination. During an interview on 08/28/2025 at 01:12 PM with the surveyor, the US FOIA (b)(6) said, NJ Exec Order 26.4b1 should never be on the floor. A review of a facility provided policy revised on 8/8/2025 titled, "Foley Catheter Care and Catheter Maintenance Guidelines" revealed under, "Urinary Catheter Maintenance" to, "Ensure that the collecting bag is secured below the level of the bladder at all times and not resting on the floor..." N.J.A.C. 8:39-19.4(a)	F0690	Continued from page 7 4. Monitoring and Quality Assurance: The Director of Nursing or designee will audit 100% of residents with indwelling catheters weekly for 4 weeks. Thereafter, 100% of residents with indwelling catheters will be audited monthly for the remainder of the quarter to ensure sustained compliance. Audit findings will be reviewed during monthly QAPI meetings to identify trends, reinforce accountability, and guide any necessary interventions. Results will be reported to the QA Committee during the Quarterly QA meeting to ensure sustained compliance	
F0000	INITIAL COMMENTS Complaints # NJ 432964, 2590775 Survey dates: 8/26/25-8/29/25 Census: 48 Sample Size: 15+ 3 Closed Records	F0000		09/22/2025

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F0000	Continued from page 8 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. A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030501	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

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S0000	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES	S0000		09/22/2025

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315394	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT THE SHORES	**2201 BAY AVENUE , OCEAN CITY, New Jersey, 08226**

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/13/2025 in relation to the 08/29/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **030501**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT THE SHORES	**2201 BAY AVENUE , OCEAN CITY, New Jersey, 08226**

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 11/13/2025 in relation to the 08/29/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315394	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT THE SHORES	2201 BAY AVENUE , OCEAN CITY, New Jersey, 08226

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K0291 SS = F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 08/27/2025 in the presence of the facilities US FOIA (b)(6) [redacted], it was determined that the facility failed to provide a functioning battery backup emergency light for 1 of 2 emergency generator transfer switch locations, independent of the building's electrical system and emergency generator in accordance with NFPA 19001: 2012 - 7.9. 19.2.9.1. This deficient practice had the potential to affect the 48 residents and was evidenced by the following: An observation on 08/27/2025 at approximately 10:59 AM inside the Emergency Generator room where 2 of 3 generator transfer switches were located, revealed one battery backup emergency light independent of the Emergency Generator. When the US FOIA [redacted] tested the emergency light, it did not function. In an interview, the US FOIA (b)(6) [redacted] confirmed the finding at the time of observation. The facility US FOIA (b)(6) [redacted] were informed of the deficient practice during the Life Safety Code Survey exit on 08/28/2025 at approximately 1:15 PM . NJAC 8:39-31.2(e) NFPA 99, 110	K0291	1. Corrective Action Taken for Affected Area On August 27, 2025, the facility removed and replaced the non-functioning battery backup emergency light located in the Emergency Generator Room near the transfer switch. The new fixture was tested and confirmed to operate independently of the building's electrical system and emergency generator, providing the required 1.5-hour duration of illumination. 2. Identification of Other Residents at Risk: All residents may be at risk due to this practice 3. Identification of Other Areas with Potential for Similar Deficiency & Systematic Change A facility-wide inspection of all battery-operated emergency lighting units was conducted on August 30, 2025 by the Lead Maintenance Staff. All other units were tested and found to be functioning properly. No additional deficiencies were identified. A Preventive Maintenance Schedule has been revised to include monthly testing of all battery backup emergency lights. A Battery Replacement Log has been implemented to track battery life and proactively replace units nearing expiration. Staff training on emergency lighting standards and testing protocols was completed on September 2, 2025, led by the Director of Building Services. Attendance was documented. 4. Monitoring and Quality Assurance The Director of Building Services will report the	09/02/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315394	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

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K0291 SS = F		K0291	Continued from page 1 results of the monthly audits of all emergency lighting systems to the Safety Committee monthly for 3 months. Results will be reported to the QA Committee during the Quarterly QA meeting to ensure sustained compliance.	
K0372 SS = F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observations, interview and review of facility provided documentation on 08/27/2025 in the presence of the facility US FOIA (b)(6) [redacted], it was determined that the facility failed to maintain the integrity of smoke barrier partitions for two (2) of three (3) smoke barrier walls observed in accordance with NFPA 101: 2012 Edition, Section 19.3.6.2.3, 8.5.6, 8.5.6.2, 8.5.6.3. This deficient practice had the potential to affect the 48 residents in the facility and was evidence by the following: A review of the facility layout identified the facility was a three (3) story building with the Long-Term Care located on the 3rd. floor and divided into three smoke zones. Observations on 08/27/2025 in the presence of the facility's US FOIA (b)(6) [redacted] revealed the following: At approximately 9:48 AM, the surveyor observed above the ceiling tiles by the double corridor smoke doors	K0372	Corrective Action Taken for Affected Area On August 28, 2025, the facility sealed the 1-1/4 inch penetration above the ceiling tiles near the Bay House smoke doors and the 1-inch penetration near the Sandy Beach smoke doors using UL-rated firestop material in accordance with NFPA standards. Repairs were verified by the Director of Facilities to restore the smoke barrier's ½-hour fire resistance rating. Identification of Other Residents at Risk: All residents may be at risk due to this practice Identification of Other Areas with Potential for Similar Deficiency & Systematic Change A full inspection of all smoke barrier walls and ceiling penetrations on the 3rd floor was completed on August 30, 2025 by the Lead Maintenance Staff. No additional unsealed penetrations were identified. A Smoke Barrier Penetration Log has been created to document all penetrations and repairs. All future penetrations will require approval and inspection by the Director of Facilities prior to completion. Staff training on smoke barrier integrity and firestop procedures was conducted on 9-2-25. Attendance was documented. Monitoring and Quality Assurance The Director of Building Services will report the results of monthly inspections of all smoke barrier walls to the Safety Committee monthly for 3 months. Results will be reported to the QA Committee during the Quarterly QA meeting to ensure sustained compliance.	09/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315394	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025

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K0372 SS = F	Continued from page 2 leading into the "Bay House" unit one approximately 1-1/4 inch hole with a BX electrical cable and a white wire running through the smoke barrier wall. At approximately 10:10 AM, the surveyor observed above the ceiling tiles by the double corridor smoke doors leading into the "Sandy Beach" unit one approximately 1-inch hole with 6 white wires running through the smoke barrier wall. In an interview, the US FOIA (b)(6) confirmed the findings at the times of observations. The facility US FOIA (b)(6) were informed of the deficient practice during the Life Safety Code Survey exit on 08/28/2025 at approximately 1:15 PM. NJAC 8:39-31.2 (e)	K0372		
K0281 SS = E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is NOT MET as evidenced by: Based on observations, interview and review of facility provided documentation on 08/27/2025 in the presence of the of the facility US FOIA (b)(6)), it was determined that the facility failed to ensure that illumination of the means of egress was provided at exits, exit doors and exit discharges in accordance with NFPA 101: 2012 Edition, Sections 7.8.1.4 and 19.2.8 This deficient practice was identified for 1 of 3 stairwell exit discharge doors, had the potential to affect all residents using this stairwell exit discharge door and was evidenced by the following: A review of the facility provided lay-out, identified there were three (3) exit stairwells leading from the	K0281	1. Corrective Action Taken for Affected Area The Director of Facilities reviewed the NFPA requirement. The second bulb in the fixture was replaced to ensure adequate illumination in Stairwell 7 exit discharge door. 2. Identification of Other Residents at Risk: All residents may be at risk due to this practice. 3. A full audit of all exit stairwells, exit doors, and exit discharge areas was conducted on 9/16/25 by the Lead Maintenance Associate under supervision of the Corporate Director of Building Services. No additional deficiencies were identified. All fixtures were confirmed to be operational and compliant with continuous illumination requirements. Systemic Changes to Prevent Recurrence A Preventive Maintenance Log has been updated to include monthly checks of all egress lighting systems. The facility has implemented a quarterly Life Safety compliance checklist to be completed by the Maintenance Associate under the supervision of the Director of Building Services.	10/31/2025

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K0281 SS = E	Continued from page 3 Long-Term Care facility located on the 3rd. floor. Observations on 08/27/2025 at approximately 11:24 AM, revealed that stairwell 7 exit discharge door was equipped with a single working light bulb. In an interview, the [redacted] confirmed the finding at the time of observation. The facility [redacted] were informed of the deficient practice during the Life Safety Code Survey exit on 08/28/2025 at approximately 1:15 PM. NJAC 8:39-31.2 (e)	K0281	Continued from page 3 Staff training was conducted to reinforce NFPA standards and the importance of egress lighting. Attendance was documented. 4. Monitoring and Quality Assurance The Director of Building Services will report the results of the monthly inspections of all egress lighting to the Safety Committee monthly for 3 months. Results will be reported to the QA Committee during the Quarterly QA meeting to ensure sustained compliance	
K0355 SS = D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 08/27/2025 in the presence of the facility [redacted], it was determined that the facility failed to 1) Perform a monthly visual examination and document the inspection on the tag attached to the fire extinguisher for 1 of 30 fire extinguishers inspected and 2) Install 1 of 30 fire extinguishers with in the required height in accordance with the National Fire Protection Association (NFPA) 10, 2010 Edition, section 6.1, 6.1.3.8.1 and 6.1.3.8, 4-3.3, 4-4.3 and 7.3.1.1. This deficient practice had the potential to affect limited residents and was evidenced by the following: Observations during the building tour in the presence of the [redacted] revealed thirty (30) fire extinguishers in various locations with the following results:	K0355	Corrective Action Taken for Affected Area On August 27, 2025, the facility documented the July 2025 monthly visual inspection for the ABC type fire extinguisher located in the Main Electrical Room. The Class "K-Wet Chemical" fire extinguisher in the Main Kitchen was remounted to a compliant height of 5 feet or less to the center of the pressure gauge, in accordance with NFPA standards. Identification of Other Residents at Risk: All residents may be at risk due to this practice Identification of Other Areas with Potential for Similar Deficiency & Systematic Change A full inspection of all fire extinguishers was completed on September 18, 2025 by the Lead Maintenance Staff. All other extinguishers were found to be properly mounted and had current inspection documentation. A Fire Extinguisher Inspection Log has been updated to include monthly visual checks with initials and dates recorded on each extinguisher tag. A mounting height verification checklist has been added to the quarterly Life Safety audit.	09/18/2025

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K0355 SS = D	Continued from page 4 1) At approximately 11:01 AM, one ABC type fire extinguisher located inside the Main electrical room was last annually inspected in January 2025 with no evidence of a monthly visual examination being performed and documented on the tag attached to the extinguisher for the month of July 2025. 2) At approximately 11:22 AM, one Class "K-Wet Chemical" fire extinguisher inside the Main Kitchen appeared to be mounted higher than 5-feet. At this time the surveyor measured and recorded the extinguisher to be installed at a height of 5 feet 7 inches to the center of the pressure indicating needle gauge. In an interview, the US FOIA (b)(6) confirmed the finding at the time of observation. The facility US FOIA (b)(6) were informed of the deficient practice during the Life Safety Code Survey exit on 08/28/2025 at approximately 1:15 PM. NJAC 8:39-31.2 (c), -31.2 (e) NFPA 10	K0355	Continued from page 4 Staff training on NFPA inspection and installation standards was conducted on September 2, 2025 by the Director of Building Services. Attendance was documented. Monitoring and Quality Assurance The Director of Building Services will report the results of the monthly inspections of all fire extinguishers to the Safety Committee monthly for 3 months. Results will be reported to the QA Committee during the Quarterly QA meeting to ensure sustained compliance.	
K0374 SS = D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observations, interview and review of facility	K0374	Corrective Action Taken for Affected Area: A new door with 1-3/4-inch thick solid bonded wood-core door rated for 20 minutes of fire resistance was ordered and is scheduled to be installed 9/29/2025. The door was verified to meet NFPA requirements and will be inspected for proper installation and functionality same day. Identification of Other Residents at Risk: All residents may be at risk due to this practice Identification of Other Areas with Potential for Similar Deficiency & Systematic Change A full inspection of all smoke barrier doors throughout the facility was completed on August 30, 2025 by the Lead Maintenance Staff. No additional deficiencies were identified.	09/30/2025

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K0374 SS = D	Continued from page 5 provided documentation on 08/27/2025 in the presence of the facility [redacted], it was determined that the facility failed to maintain the 20 minute fire rating of smoke doors in accordance with Life Safety Code 101, 2012 Edition, 19.3.7.6, 19.3.7.8, 19.3.7.9 and 8.5.4.1.This deficient practice had the potential to affect the Residents on the Bay House unit and was evidenced by the following: A review of the facility provided lay-out identified that there were three (3) smoke zones. Observations on 08/27/2025 in the presence of the [redacted] at approximately 9:46 AM, revealed the corridor double smoke doors leading into the Bay House unit. The right smoke door was broken and missing an approximately 6-inch by 4-1/2 inch section of the door. This compromised the 20-minute fire rating of the door. In an interview, the [redacted] confirmed the findings at the times of observations. The facility [redacted] were informed of the deficient practice during the Life Safety Code Survey exit on 08/28/2025 at approximately 1:15 PM. NJAC 8:39-31.2 (e), -31.2(c).	K0374	Continued from page 5 A Smoke Door Inspection Log has been implemented to document monthly visual checks and any repairs. All future repairs or replacements of smoke barrier doors will require verification of fire rating and inspection by the Director of Facilities. Staff training on smoke barrier door standards and inspection protocols was conducted on September 2, 2025. Attendance was documented. Monitoring and Quality Assurance The Director of Building Services will report the results of monthly inspections of all smoke barrier doors to the Safety Committee monthly for 3 months. Results will be reported to the QA Committee during the Quarterly QA meeting to ensure sustained compliance.	
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/27/2025 and 08/28/2025, and the facility was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. United Methodist Communities is a 3-story building that was built in the 90's. It is composed of Type II protected construction. The Long-Term Care facility is located on the third floor, with common areas on the first floor. The 3rd. floor is divided into three smoke zones. The facility has Diesel Emergency Generator. The current census is 48 Residents.	K0000		09/22/2025

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E0000	Initial Comments United Methodist Communities at Shores was in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance CFR 483.73, Requirements for Long Term Care (LTC) Facilities.	E0000		09/22/2025

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K0000 Bldg. 01	INITIAL COMMENTS An onsite revisit was conducted on 11/18/2025 to verify the facility's Plan of Correction for the 8/29/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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