STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315394	A. BUILDING _____ B. WING _____	C 02/20/2024

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

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F 000	INITIAL COMMENTS COMPLAINT # NJ 168679 Standard Survey Census: 50 Sample Size: 17 + 2 closed records A Recertification survey was conducted and the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the	F 582		3/25/24

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

Electronically Signed | 03/10/2024

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F 582	Continued From page 1 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to issue the proper required Skilled Nursing Advance NJ Exec Order 26.4b1) for 2 of 3 residents (Resident #22, and Resident #43) reviewed for NJ Exec Order 26.4b1 . This deficient practice was evidenced by the following:	F 582	The Care Coordinator generated and the Social Worker issued the SNFABN for the date of NJ Exec Order 26.4b to the responsible party of resident #43. A SNFABN was not issued to the responsible party of resident #22 as the resident NJ Exec Order 26.4b1 prior to the NJ Exec Order 26.4b1 of the recertification survey. The US FOIA (b)(6) received education related to the provision	

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F 582	Continued From page 2 On 02/14/2024, the US FOIA (b)(6) provided the surveyor with a list of residents who were discharged from the facility within the last NJ Exec [redacted] and should have received Beneficiary Notices. The surveyor reviewed two of the residents (Resident #22, and Resident #43) NJ ex order [redacted] On 02/16/2024 at 10:34 AM, the surveyor reviewed the SNF Beneficiary Protection Notification Review (SNFBPNR) completed by the facility for Resident #22. The SNFBPNR indicated the Resident #22's NJ ex order 26.4b1 [redacted] and Resident #22 NJ ex order 26.4b1 [redacted] The SNFBPNR further revealed that both a SNFABN and a Notice of Medicare Non-Coverage (NOMNC) were provided to the resident or the resident's representative.The facility was unable to provide a signed SNFABN for the date of NJ Exec Order 26.4b1. On 02/16/2024 at 10:34 AM, the surveyor reviewed the SNF Beneficiary Protection Notification Review (SNFBPNR) completed by the facility for Resident #43. The SNFBPNR indicated the Resident #43's NJ ex order 26.4b1 [redacted] and Resident #43 NJ ex order 26.4b1 [redacted] The SNFBPNR further revealed that both NJ ex order 26.4b1 [redacted] The facility was unable to provide a signed SNFABN for the date of NJ ex order 26.4b1	F 582	of SNFABNs. All residents who experience a change in coverage by Medicare or Medicaid may be at risk for this practice. A business process for the formulation and delivery of SNFABNs was written in accordance with regulatory requirements. The US FOIA (b)(6) [redacted] were educated on the requirement to deliver advanced beneficiary notice when a change in coverage by Medicare or Medicaid occur and the new business process outlining the procedure. All active charts were audited to ensure SNFABNs were delivered and on file for qualified changes in coverage. Upon qualifying payor change, the Care Coordinator will draft the SNFABN and the Social Worker will inform and deliver the notice to the resident and/or responsible party. The Business Office Manager will audit the charts of residents who experienced a change in coverage by Medicare or Medicaid to ensure a SNFABN and/or NOMNC is on file weekly for 4 weeks, then monthly for 2 months. Results of all audits will be documented and reported monthly to the Quality Assurance Performance Improvement (QAPI) Committee.	

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F 582	Continued From page 3 On 02/16/2024 at 10:40 AM, the surveyor interviewed the US FOIA (b)(6) who stated that she only does an initial SNFABN on long term care and that if they go out to the hospital and return to the facility, she does not get another SNFABN. She further stated that she doesn't have a policy on SNFABN's. NJAC 8:39-4.1a(8)	F 582		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records, other facility documentation, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool, for 2 of 17 residents reviewed (Resident #29 and Resident #101). This deficient practice was evidenced by the following: 1. On 02/12/2024 at 11:10 AM, the surveyor observed Resident #29 out of bed in a wheelchair. The resident was first seen in the library. The nurse stated that the NJ ex order 26.4b1 [redacted]. Resident was seen coming back into unit from library. Resident #29 was very NJ Exec Order 26.4 and stated NJ Exec Order 26.4b1. The surveyor review of Resident #29's admission record indicated that the resident was admitted with diagnoses that included, but were not limited to; NJ ex order 26.4b1	F 641	Residents #29 and Resident #101 NJ ex order 26 [redacted] MDS (Minimum Data Set) assessments have been resubmitted. The US FOIA (b)(6) was immediately provided education on RAI manual guidance on Section J1700 to 1900 Fall history completion. All residents with falls and falls with injury have the potential to be affected by this cited practice. All residents with falls and falls with injury in the last 6 months MDS (Minimum Data Set) assessments was audited to ensure accurate coding of falls. Any inaccuracy in section J1700 to J1900 of the MDS	3/25/24

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F 641	Continued From page 4 A review of Resident #29's medical record indicated that on NJ ex order 26.4b1, the resident was NJ Exec Order 26.4b1 in the room. NJ Ex[redacted]. A review of the Quarterly Minimum Data Set (MDS), an assessment tool, dated 1 NJ ex order 26.4b1 indicated a Brief Interview of Mental Status (BIMS) was NJ[redacted], indicating NJ ex order 26.4b1 and Section NJ[redacted] was coded to indicate NJ Exec Order 2[redacted] had happened since last assessment. On 02/15/2024 at 12:30 PM, the surveyor interviewed the US FOIA (b)(6), who confirmed that the NJ Ex[redacted] was not coded on that MDS and should have been. 2. The surveyor review of Resident #101's admission record indicated that the resident was NJ ex order 26.4b1 with diagnoses that included, but were NJ ex order 26.4b1. A review of Resident #101's medical record indicated that on NJ ex order 26.4b1 the resident NJ ex ord[redacted] Resident #101 NJ ex order 26.4b1 A review of the Discharge MDS dated NJ ex order 26.4b1, indicated NJ ex order 26.4b1 and Section J was coded to indicate NJ ex order 26.4b1. On 02/16/2024 at 11:15 AM, the surveyor interviewed the US FOIA (b)(6) who stated that only NJ Exec Order 26[redacted] should've been coded as NJ Exec Order 2[redacted]	F 641	(Minimum Data Set) assessment that are identified, a modification to the assessment will be completed as warranted. The MDS Coordinator will be provided re-education on the community□s risk management program and fall tracking method to ensure accuracy of the MDS assessments. Prior to closing the MDS assessments, the MDS coordinator will re-validate the accuracy of section J1700 to J1900 prior to submission to ensure accuracy. The Medicare Reimbursement Specialist will randomly review 15 MDS assessments for the accuracy of section J1700 to J1900 of the MDS assessment weekly x 4 weeks then week for 4 weeks, then 10 MDS assessments per month for 2 months. Results will be documented and reported monthly to the Quality Assurance Performance Improvement (QAPI) Committee.	

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F 641	Continued From page 5 with [redacted] and the other two area should've been coded as [redacted] with [redacted] and [redacted] except for [redacted] according to the RAI instructions. A review of the RAI User's Manual Version 1.17.1 dated October 2019 revealed ... Chapter 3 MDS Items ... Section J: Number of falls ... Determine the number of falls that occurred since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS) and code the level of fall-related injury for each. Code each fall only once. If the resident has multiple injuries in a single fall, code the fall for the highest level of injury. A review of a facility policy titled "Resident Assessment Instrument (RAI) Completion", revised 4/11/2019, includes, "The person who completes each section must sign the MDS to verify accuracy of the sections completed." N.J.A.C 8:39-11.1	F 641		
F 656 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	F 656		3/25/24

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F 656	Continued From page 6 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 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 observation, interview, and review of pertinent facility documents, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan to meet a resident's medical needs and failed to	F 656	The Care Plan for Resident #21 was updated to include the application of the NJ ex order 26.4b1 [redacted] The US FOIA (b)(6) identified was educated on the policy for	

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F 656	Continued From page 7 implement focus and interventions that are specific to the resident's NJ ex order 26.4b1 . The deficient practice was identified for 1 of 1 (Resident #21) investigated for NJ Exec Order 26.4b1 and NJ Exec Order 26.4 The deficient practice was evidenced by the following: During the initial tour of the facility on 2/12/2024 at 10:29 AM, the surveyor observed Resident #21 sleeping in his/her NJ Exec chair in the unit hallway. Resident #21 was observed NJ ex order 26.4b1 On 2/14/2024 at 12:03 PM, the surveyor observed Resident #21 in the dining area in his/her NJ Exec chair waiting for lunch. Resident #21 was observed NJ ex order 26.4b1 According to the Admission Record, Resident #21 was admitted to the facility with the following but not limited to diagnoses: NJ ex order 26.4b1 According to the 12/18/2023 Comprehensive Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, Resident #21 NJ ex order 26.4b1 Section GG of the MDS revealed Resident #21 NJ ex order 26 Section I revealed Resident #21 NJ ex ord	F 656	NJ Exec Order 26.4b1 and the policy on Comprehensive Care Plans which includes updating the care plan in accordance with the intervention ordered by the physician. All residents using heel protectors to offload heels have the potential to affected by this cited practice. A care plan audit was completed on all residents with heel protectors to ensure compliance. No other issues identified. Licensed Nurses will be provided education related to the community policy for heel protectors and the importance of obtaining orders and communicating the treatment intervention for the care plan. The DON has implemented a daily meeting with the nurse mentors to review clinical changes and preventive measures to ensure timely revisions to the care plan and orders have been obtained. A list will be maintained on all residents identified needing heel protectors as a preventive measure to ensure the care plan has been revised and an order has been obtained. The DON (Director of Nursing) will randomly complete an observation audit on each household for heel boot application and compare to list to ensure compliance with care plans and physician orders weekly x 4 weeks and then monthly x 2 months. Immediate corrective action will be facilitated if warranted. Results of these audits will be documented and reported monthly to the	

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F 656	Continued From page 8 A review of Resident #21's Care Plan date initiated [redacted] revised on [redacted], revealed that [redacted] On 2/15/2024 at 9:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #2). LPN #2 stated, "[redacted] I do not apply them unless they are on the Treatment Administration Record (TAR) for me to apply them." The surveyor then asked what the purpose of the [redacted] LPN #2 stated, [redacted] LPN #2 also stated, "There should be a physicians order for them, and it should also be listed on his/her care plan." On 2/15/2024 at 10:05 AM, the surveyor conducted an interview with the Certified Nursing Assistant (CNA #1). CNA #1 stated, "[redacted] Resident #21 [redacted] The surveyor then asked who was responsible for ordering the [redacted]. CNA #1 said she wasn't sure who orders them. If they are ordered the nurse will relay the information to the CNA's. She also stated, "It will be added to our task page that we sign off and it should be added to their care plan." On 2/16/2024 at 1:08 PM during an interview with the surveyors, the surveyor asked how you	F 656	Quality Assurance Performance Improvement Committee.	

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F 656	Continued From page 9	F 656		

identify a resident at risk for NJ Exec Order 26.4b1 [redacted]. The US FOIA (b)(6) [redacted]) stated, "We complete the NJ Exec Order 26.4b1 [redacted] on admission and quarterly. If a resident is at NJ Exec Order 2 [redacted] we would either offload the NJ Exec Ord [redacted] with NJ Exec Order [redacted] or use the b NJ Exec Order 26.4b1 [redacted] There would be a physicians order for the NJ Exec Order 26.4b1, and the nursing department will provide them." The surveyor then asked, should the intervention in place be included on the resident's care plan. The US FOIA (b) [redacted] stated, "Yes, if they are using the NJ Exec Order 26.4b1 it should be included on the care plan."

The surveyor reviewed the facility policy titled: Care Plan, revised 11/9/2023. The following was revealed under Procedure:

9. "The care plan shall identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident's strengths, limitations and goals. The care plan shall be complete, current, realistic, time specific and appropriate to the individual needs for each resident."

32. "When there are changes in the resident's condition, the Comprehensive Care Plan is updated as needed to change goals, time frames, or interventions."

The surveyor reviewed the facility policy titled: Pressure Injury Prevention & Managing Skin Integrity, revised 7/14/2021. The following was revealed under Policy: "Pressure ulcer/injury interventions, based on the resident's Braden assessment, will be implemented by nursing, and documented in the clinical HER. Skin care intervention when appropriated will be

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F 656	Continued From page 10 documented on the care plan." The surveyor reviewed the facility policy titled: Heel Protectors, revised 2023. The following was revealed under Policy: Residents will be provided with heel protectors when indicated on the Care Plan for preventative skin care, or as ordered by physician or charge nurse. N.J.A.C. 8:39-11.2 (e)2	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain professional standards of nursing practice for not obtaining a physician's order. The deficient practice was identified for 1 of 1resident (Resident #21) investigated for [redacted] and [redacted] The deficient practice was 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	F 658	Immediately upon the surveyor notification, NJ ex order 26.4b1 [redacted] for Resident #21 and the care plan intervention tasks for the CNAs were updated and communicated. All residents have the potential to affected by this cited practice. Licensed Nurses will be provided education related to the community policy for heel protectors and the importance of obtaining physician□s orders and communicating the treatment intervention to the care plan. The DON (Director of Nursing) has implemented a daily meeting	3/25/24

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F 658	Continued From page 11 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 wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." 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 licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." During the initial tour of the facility on 2/12/2024 at 10:29 AM, the surveyor observed Resident #21 sleeping in his/her NJ ex order 26.4b1. Resident #21 was observed NJ ex order 26.4b1. On 2/14/2024 at 12:03 PM, the surveyor observed Resident #21 in the dining area in his/her NJ ex order 26.4b1 waiting for lunch. Resident #21 observed NJ ex order 26.4b1. According to the Admission Record, Resident #21 was admitted to the facility with the following but not limited to diagnoses: NJ ex order 26.4b1 [redacted]	F 658	with the Nurse Mentors to review clinical changes and preventive measures to ensure timely revisions to the care plan and that orders have been obtained. A list will be maintained on all residents identified needing heel protectors as a preventive measure to ensure the care plan has been revised and a physician□s order has been obtained. The DON (Director of Nursing) will randomly complete an observation audit on each household for heel boot application and compare to list to ensure compliance with care plans and physician orders weekly x 4 weeks and then monthly x 2 months. Immediate corrective action will be taken if warranted. Results of these audits will be documented and reported to the Quality Assurance Performance Improvment Committee monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315394	A. BUILDING _____ B. WING _____	C 02/20/2024

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F 658		F 658		

Continued From page 12

According to the [NJ Exec Order 26.4b1] Comprehensive Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, Resident #21 [NJ ex order 26.4b1] Section [NJ Exec] of the MDS revealed Resident #21 [NJ ex order 26.4b1]. Section [NJ] revealed Resident #21 had an active diagnosis of [NJ ex order 26.4b1]

A review of the Physician Order Summary Report (POS) located in the electronic medical record (EMR) revealed that Resident #21 [NJ ex order 26.4b1].

On 2/15/2024 at 9:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #2). LPN #2 stated, "The aid applies the [NJ Exec Order 26] when he/she gets out of bed to go into the [NJ Exec] chair. I do not apply them unless they are on the Treatment Administration Record (TAR) for me to apply them." The surveyor then asked what is the purpose of the [NJ Exec Order 26.4b1]. LPN #2 stated, "The resident uses them to [NJ Exec Order 26.4b1] and it helps [NJ Exec Order 26] " LPN #2 also stated, "There should be physicians order for them, and it should also be listed on his/her care plan."

On 2/15/2024 at 10:05 AM, Surveyor conducted an interview with the Certified Nursing Assistant (CNA #1). CNA #1 stated, [NJ ex order 26.4b1]. Resident #21 [NJ ex order 26.4b1]

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F 658	Continued From page 13 NJ ex order 26.4b1 ." The Surveyor then asked who orders the NJ Exec Order 26.4b1 CNA #1 said she wasn't sure who orders them. If they are ordered the nurse will relay the information to the CNA's. She also stated, "It will be added to our task page that we sign off and it should be added to their care plan." A review of Resident #21's "Task" in the EMR NJ ex order 26.4b1 On 2/16/2024 at 1:08 PM during an interview with the surveyors, the surveyor asked how you identify a resident at risk for NJ Exec Order 26.4b1 The US FOIA (b)(6) stated, "We complete the NJ Exec Order 26.4b1 on admission and quarterly. If a resident is at risk for NJ Exec Order 26.4b1, we would either NJ Exec Order 26.4b1 or use the NJ Exec Order 26.4b1 There would be a physicians order for the NJ Exec Order 26.4b1, and the nursing department will provide them." The surveyor reviewed the facility policy titled: Heel Protectors, revised 2023. The following revealed under Policy: Residents will be provided with heel protectors when indicated on the Care Plan for preventative skin care, or as ordered by physician or charge nurse.	F 658		
F 759 SS=E	NJAC 8:39-27.1(a) Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		3/25/24

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F 759	Continued From page 14 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to ensure that all medications were administered without error rate of 5% or less. During medication pass observation on 02/14/2024, the surveyor observed one nurse administer medications to five residents. There were 26 opportunities and 2 errors which calculated to a medication administration error rate of 7.69%. This deficient practice was identified for 2 of 5 residents, (Resident #105 and Resident #106) and was evidenced by the following: On 02/14/2024 at 7:18 AM, the surveyor observed Licensed Practical Nurse (LPN #1) prepare and administer NJ ex order 26.4b1 [redacted] to resident #105. The NJ Exec Order 26.4b1 package had a red Cautionary label on the package from the pharmacy to take with food. There was no food observed in Resident #105's room and LPN #1 did not offer the resident any food. At that time the surveyor asked Resident #105 if he/she had eaten breakfast. Resident #105 replied, "No." At that time the surveyor requested LPN #1 to read the package cautionary and LPN #1 told the surveyor, "Give with food." LPN #1 then explained that the facility practice is they (the nurses) give the medications and then the aides bring the	F 759	Residents #105 and #106 were assessed by the RN nurse mentor. Residents #105 and #106 NJ ex order 26.4b1 [redacted] Resident #105 and #106 residents physicians, the resident's representative and consultant pharmacist were informed. LPN#1 was provided re-education on medication administration with emphasis on following the medication precautionary. An immediate medication observation was completed on LPN #1 and no errors were identified. The DON will initiate a performance enhance plan for LPN#1 increased random med pass observations by the Staff Educator. All residents receiving medication that have precautionary statements have the potential to be affected by this cited practice. The Staff Educator will re-educate all licensed nurses on the community's policy on Medication Management Guidelines with emphasis on proper medication administration practices, importance of following the medication precautionary statements and the medication error rate. A post test will be administered to ensure competency and understanding. Med Pass Observations will be performed	

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F 759	Continued From page 15 breakfast. LPN #1 again stated, "Our system is the resident wakes up, we give the med's (medications) and then they get breakfast." On 02/14/2024 at 08:00 AM, the surveyor observed LPN #1 prepare and administer NJ ex order 26.4b1 to Resident #106. A cautionary statement on the Medication Administration Record (MAR) indicated "Take with meal or immediately after a meal." LPN #1 did not offer Resident #106 any food at the time of administration.. At that time the surveyor asked Resident #106 if he/she had eaten breakfast and Resident #106 replied, "Soon." At 8:04 AM, LPN #1 said her next step would be to get Resident #106 breakfast. Resident #106's breakfast was delivered at 8:18 AM. A review of Resident #105's Admission Record revealed Resident #105 was admitted with diagnoses including but not limited to: NJ ex order 26.4b1 A review of the Order Summary Report revealed a physician NJ ex order 26.4b1 A review of the Admission Record revealed Resident #106 was admitted to the facility with diagnoses including but not limited to: NJ ex order 26.4b1	F 759	by the Staff Educator/designee as follows: Two (2) Med Pass observations per week for 4 weeks, then four (4) Med Pass observations per month for 2 months will be completed to ensure compliance. Just-in-time education will follow any gaps in practice. Results of these Med Pass observations will be documented and reported monthly to the QAPI Committee.	

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F 759	Continued From page 16 During an interview with the surveyor on 02/16/2024 at 1:01 PM, the acting US FOIA (b)(6) was asked wby the surveyor what is your expectation for nurses when they are passing the medications and a medication has a cautionary statement. The acting US FOIA (b)(6) replied, "I expect the nurses to follow the cautionary statements." The surveyor questioned what is not considered food and the acting US FOIA (b) replied "Crackers, milk, and applesauce are not considered food." A review of a facility policy titled Medication Management Program Guidelines (RS-10) with a last approved date of 11/6/2023, revealed under the Procedure section: "Cautionary Statements shall appear on the residents record of medication administration and the system shall include provisions for noting additional information, including but not limited to special times or routes of administration and storage conditions." N.J.A.C 8:39-29.2(d)	F 759		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16	F 809		3/25/24

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F 809	Continued From page 17 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of other facility documentation, it was determined that the facility failed to consistently offer nighttime snacks to all residents on a nightly basis. This deficient practice was identified for 4 of 5 residents (Residents #11, Resident #35, Resident #39, and Resident #251) during the Resident Council group meeting and was evidenced by the following: On 02/14/2024 at 10:15 AM, the surveyor conducted a group meeting with five residents who were selected by the facility. Four of the five residents stated that they were not offered evening snacks; however, they did state you can ask for anything and they will bring it to you. On 02/14/2024 at 12:33 PM, the surveyor interviewed Certified Nursing Assistant (CNA #1) who stated that usually the aide will offer snacks to the residents, or the activity aide will do it before they leave for the night. When asked what time the snacks are given, CNA #1 replied she was not sure what time snacks are given. On 02/16/2024 at 01:04 PM, surveyor interviewed the US FOIA (b)(6)), who stated that	F 809	Residents #11, #35, #39, #251 are now being offered a snacks. All residents may be affected by this practice. All CNAs and Licensed Nurses were educated on the importance of offering and providing a bedtime snack to all residents as well as documenting task completion of refusal or acceptance of a snack for each resident. To ensure compliance, bedtime snack has been added to the medication administration record to reflect nurse oversight that the provision of a snack was provided. Resident Council convened and residents were informed that there were a wide variety of snacks available to them 24/7. Residents were further informed that CNAs will offer a daily bedtime snack. The DON will utilize the Medication Administration Record for auditing the offering of HS snacks for 10 residents weekly for 4 weeks, then 20 residents monthly for 2 months. Results will be documented and reported to the QAPI	

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F 809	Continued From page 18 the staff should be offering evening snacks to everyone, not just if the resident asks for one. On 2/20/2024 at 12:21 PM, the surveyor interviewed Licensed Practical Nurse (LPN #3), who stated that the CNAs usually hand snacks out at night and that they ask everybody. LPN #3 was not sure what time this is done. On 2/20/2024 at 12:30 PM, the surveyor interviewed the [redacted] who stated that the CNAs hand snacks out in the evening. She also stated that sometimes the nurses do it. When asked what time snacks are handed out, she stated sometime in the evening, after dinner, before bed. Facility mealtimes as provided by the facility to team on entrance notes that breakfast is at 7:30 AM, Lunch is at 12:00 PM, Supper is at 5:30 PM, and evening snack is at 7:00 PM. A review of a facility policy titled "Hydration and Snack", revised 2/14/2024, indicates: "Preferred snacks will be stocked and accessible at preferred times. Snacks will always be available on a 24-hour basis in order that all preferences are accommodated." "At the specified times that snacks are provided, nursing assistants will offer snacks to residents who choose to remain in their rooms and to those who retire early in the evening." N.J.A.C. 17.4 (b)	F 809	(Quality Assureance Performance Improvement) Committee monthly.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		3/29/24

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F 812	Continued From page 19 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 2/12/2024 from 9:19 to 10:05 AM the surveyor, accompanied by the US FOIA (b)(6) [redacted], observed the following in the main kitchen: 1. On an upper shelf in the dry storage room a container of Ground Thyme was dated "1/9/2." The surveyor asked the US FO [redacted] if the container of thyme was dated 2022,2023, or 2024. The US FO [redacted] could not tell the surveyor how old the thyme was or when it was placed on the shelf. The US FO [redacted] removed the thyme to the trash. On a lower shelf in a previously opened card board box, a	F 812	The incompletely dated ground thyme, undated pasta, opened undated ketchup, au jus with a past discard date and the incompletely labeled quiche were discarded. The sheet cake was confirmed to have been made that day and was cooling in the walk-in before icing. The sheet cake was covered and dated with the date of 2/12/24 and discard date of 2/15/24.The undated dated deli meat was confirmed as prepared on Sunday 2/11/24. It was re-covered and dated with the prep date of 2/11/24 and discard date of 2/14/24. The cord was removed from the mixing bowl, the bowl was sanitized, and the cord was cleaned. The fixed asset was then recovered. The plastic wrap that was identified as opened was immediately closed.	

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F 812	Continued From page 20 previously opened bag of pasta had no dates. The [US FO] removed the pasta to the trash and agreed that the bag had no dates. In addition, on an upper shelf a previously opened container of Heinz tomato ketchup had dried ketchup covering the lid of the bottle. The [US FO] agreed that it was dirty and could not identify when the bottle was opened or the use by date. Observation of the bottle of ketchup did not reveal a manufacturers use by date. 2. On a middle shelf of the walk-in refrigerator a soup tureen contained beef au jus, as identified by the [US FO] The plastic wrap covering the au jus was torn and the au jus was exposed. The plastic wrap had a date of "2/4" and "2/7." [US FO] agreed that the au jus was expired and exposed. 3. A mobile 4 wheeled multi-tiered cart in the walk-in refrigerator contained a sheet pan with a vanilla cake on a middle rack. The cake was uncovered and exposed. On a separate cart a sheet pan contained sliced deli meat prepped for the dinner meal and covered with paper. The sheet pan had no dates to indicate when the product was produced or when the product was to be used by. 4. In the walk-in freezer on an upper shelf, (2) packages of individual quiches had been removed from their original container. The quiches had a "prep date" of "5/11" and a "use by" date of "5/15." The EC could not tell the surveyor what year they were prepped or how long the freezer storage period would be. The quiches were observed to be covered with frost on the inside of the packages. 5. A stand-up mixer was covered with a plastic	F 812	The technician observed without a hairnet in the kitchen donned a hairnet. The light shield and metal channels above the steam table were cleaned, the dust-like substance around both fire sprinkler heads and the power supply line were cleaned by the maintenance staff member. The walls and ceiling in the prep area and the walls and ceiling above the entry door to the refrigeration unit were cleaned by the maintenance staff and dining service staff. The ceiling tiles above the steam table were replaced by in house maintenance staff, and the support column was cleaned by dining staff. Upon identification, the stacks of bowls immediately were brought to the dish room by the Dining Services Director and they were washed and sanitized. The Director of Dining Services began re-education related to labelling and dating, discarding expired food, sanitation of fixed assets, and cleaning of walls, ceiling and columns immediately with kitchen staff scheduled that day. In addition, the Administrator confirmed a policy for hairnet use/hair covering and a policy for storage of dishes and utensils was present in the Dining Department Policy Manual and reviewed the requirement to provide any Surveyor policies and documents timely upon request.	

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F 812	Continued From page 21 bag and was not in current use. The US FO stated that the mixer was not in use and that the mixer was cleaned and sanitized. The surveyor had the US FO remove the plastic bag to inspect the mixer for cleanliness. Upon removal of the plastic bag the surveyor observed that the electric power cord was placed inside of the cleaned and sanitized mixer bowl where food ingredients are prepared and mixed. The cord was observed to be covered with unidentifiable debris. The US FO then removed the contaminated mixer bowl and instructed kitchen staff to clean and re-sanitize the mixer bowl. The US FO agreed on interview that the power cord should not be stored within the cleaned and sanitized mixer bowl. On 2/15/2024 from 9:38 to 10:37 AM the surveyor, accompanied by the US FOIA (b)(6) observed the following in the main kitchen: 1. (2) containers of plastic wrap were resting on top of the loading area/prep table. The boxes were opened, and the plastic wrap was exposed. Both containers had cardboard lids attached and opened. On interview the US FOIA stated, "They should be closed when not being accessed." 2. The surveyor observed the ice machine maintenance technician in the kitchen during food production. The technician was conducting quarterly maintenance/deep cleaning of the kitchen ice machine, according to the US FOIA The technician was observed kneeling in front of the ice machine. The technician had no hair net/covering and their hair was exposed. The US FOIA stated that she had previously told the technician that a hair net/covering was required to be worn while in the kitchen. The US FOIA was observed to then tell the technician to donn a hairnet/covering.	F 812	All residents may be at risk due to these practices. TThe Dining Services Director/Designee re-educated department staff on the policy for labelling and dating; discarding expired goods; dating of individual goods received in a bulk container; the storage of dishes/small wares; the closure of plastic wrap when not in use; and cleaning, sanitizing and proper storage of fixed assets in the kitchen. In addition, education on the requirement of hairnet use in the kitchen and reorientation to the hairnet receptacle already established and clearly labelled was provided to the kitchen and maintenance staff. Ceiling tiles were replaced and education was provided on cleaning of dust debris on metal grids, ceiling tiles and columns as well as the placement of work orders as necessary for task completion. The cleaning and maintenance of the ceiling, power cord in walk-in, cage around fire sprinklers and fan were placed on a preventative maintenance schedule for the maintenance staff to clean. The kitchen ceiling is scheduled for replacement during Q2 2024. The Administrator, Regional Account Manager and Dining Services Director reviewed and adjusted the Utility Weekly Work Sheet to include cleaning of the	

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F 812	Continued From page 22 3. The surveyor observed dust accumulation on the ceiling tiles/metal channels above the steam table, where resident food is prepped and served. In addition, dust accumulation was observed on the light shield/cover above the food production area/steamtable for the overhead lighting. The surveyor utilized a step stool to gain access to the ceiling and determined that dust accumulation was present after doing a finger swipe on the surface of the light cover. In addition, a grease-like and dust substance was determined to exist on the ceiling panel/tile in the food production area above the range/oven unit. This was determined by a finger swipe by the surveyor. A support column adjacent to the steam table was noted to have an accumulation of a dark, unidentified substance on the upper area of the column and extending down approximately 1 foot from the ceiling. On closer inspection the surveyor was able to determine that the substance was a dark dust-like substance. On interview the [US FOIA] replied to the surveyor, "Ok," when asked by the surveyor if the dust accumulation in the food production area could possibly contaminate food or exposed dishware/equipment in the food production area. The [US FOIA (b)] upon further questioning did agree to the surveyor that the dust could be a potential source of contamination and also stated that the ceiling was not currently included on the kitchen cleaning schedule. 4. (3) stacks of bowls in a well on the steam table were not inverted or covered and were exposed to contamination. Active food production was not taken place at the time. On interview, the [US FOIA] stated, "They should be inverted or covered to prevent contamination when not in active use."	F 812	ceiling and the walls in the walk-in refrigerator and the support columns and monitoring of the ceiling in the main kitchen. The Administrator and Regional Account Manager re-educated the US FOIA (b)(6) [redacted] on communicating expectations related to completion of cleaning tasks, supervisors auditing the assigned work and holding staff accountable when there is a performance gap. The Dining Services Director/designee and the Administrator will audit cleanliness and sanitation of the refrigerator walls, ceilings and grid covering the sprinkler and sprinklers; the kitchen ceiling and walls; the ceiling tiles, metal grid, and support columns; and fixed assets. The audit will also include the storage of dishes, small wares and closure of foil/saran wrap boxes. The audits will be completed weekly for 4 weeks, then monthly for 2 months for compliance. Results will be documented and reported to monthly to the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315394	A. BUILDING _____ B. WING _____	C 02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT THE SHORES	2201 BAY AVENUE OCEAN CITY, NJ 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
F 812	Continued From page 23 5. The surveyors observed a dust-like substance throughout the walk-in refrigerator, The dust-like substance was on the wire cage surrounding the fire sprinkler head on the ceiling, along the conduit covering the electric power supply line along the wall of the refrigerator to the left of the entry door, the ceiling of the walk-in, and dust and what appeared to be a mold- like substance was above the refrigeration unit and on the ceiling in front of the refrigeration unit entry door. The fans were actively running during the observation and the potential existed to have dust and mold contaminate the refrigerated food supply. On interview the US FOI and US FOI agreed that the "walk-in was full of dust and also had mold on the ceiling. The US FOI stated to the surveyor that "we clean the walk-in but not the walls and ceiling as part of our current cleaning schedule." The surveyor reviewed the facility policy titled Food Safety Product Labeling and Dating Guidelines, Document Code: 1.2.19, and Revision Date: 12/06/2022. The following was indicated under the heading Purpose and Scope: "Assist with the labeling requirements on food products and use-by-dates." Under Receiving/Storing (Dry or Frozen) - Rotation System the following was observed: "Date cartons, cases, boxes. etc., with "date received." This is not needed - if products remain in master cases already dated by the manufacturer."" "In order to maintain traceability of food products during a potential recall it is recommended to transfer the lot number and/or the manufacture date of the product to the new container if	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315394	A. BUILDING _____ B. WING _____	C 02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT THE SHORES	2201 BAY AVENUE OCEAN CITY, NJ 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
F 812	Continued From page 24	F 812		

removing contents from the original packaging for storage."

The following was revealed under the heading Date Marking Time Control for Food Safety:

"[company name/vendor] policy using the 2017 FDA Food Code as guidance specifies ready-to-eat, time/temperature control for safety (TCS) food prepared in a food establishment and held longer than the subsequent meal period must be marked to indicate the date or day by which the food is to be consumed on the premises, sold, or discarded when held at a temperature of 5 C (Celsius) (41 F(Fahrenheit)) or less for a maximum of 7 days." In addition, the following was revealed under the heading Date Marking Non Time Control for Food Safety:

"The FDA Retail Food Code and [company/vendor name] policy exempts non-time control for food safety from the date marking requirements. However, Joint Commission and CMS may require dating of all opened products for stock rotation purposes. These dates are for quality purposes only and do not pose a food safety risk. Non-TCS if dated should use the manufacturer's use by date or operations can use the [company/vendor name] Product Quality Assurance Shelf Life Guidelines for guidance on dates. Once a product does have a documented use by date, the FDA Food Code and [company name/vendor] Policy requires the product to be consumed or discarded by that date. It is important to date food properly to avoid unnecessary disposal of safe food."

The surveyor reviewed the facility provided policy titled Cook's Daily Cleaning Schedule, Utility

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	315394	A. BUILDING _____ B. WING _____	C 02/20/2024

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

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F 812	Continued From page 25 Dating Cleaning Schedule, and Utility Weekly Cleaning Schedule, undated. Review of the (3) kitchen cleaning schedules revealed that per the Utility Weekly Cleaning Schedule, "Walls/Columns" were to be cleaned weekly. The (3) facility provided cleaning lists did not address cleaning of the kitchen ceiling and they did not address cleaning of the walk-in refrigerator ceiling or walls. The facility failed to provide a copy of their hair net/covering policy and storage of dishes/utensils when not in use as requested by the surveyor. NJAC 18:39-17.2(g)	F 812		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F 947		3/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315394	A. BUILDING _____ B. WING _____	C 02/20/2024

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

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F 947	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to ensure 1 of 5 Certified Nursing Assistants (CNA #3) received 12 hours of required education annually. This deficient practice was evidenced by the following: The surveyor reviewed five (5) random CNA education files for the year [NJ Exec Ord] A review of a transcript for CNA#3 titled, "SYMPIR LEARNING," revealed the following: CNA #3 completed 10.75 hours. During an interview with the[US FOIA (b)(6)]) on 02/14/2023 at 12:16 PM, she stated that the CNA was responsible to complete the yearly mandatory 12 hours of education to include both the Abuse training and the Dementia training. The [US FOIA (b)] stated that she could not speak to why the CNA training was not completed. During an interview with the [US FOIA (b)(6)] on 02/15/2024 at 11:43 AM, she stated that they are aware that the staff are not completing their yearly mandatory education and are reviewing their processes. A review of a facility policy titled, "Clinical Staff Competency (RS-52)" with a revised date of 03/23/2023, revealed under "Competency Content;" "Required in-service training, specific to nurse aides, will include at least 12 hours per year. Topics for education include all in-services required by state agency NJSHSS, CMS, and	F 947	The staff member identified as not meeting the educational requirement completed the mandatory 12 hours of education requirement for the year. All Certified nursing aides and residents have the potential to be affected by this cited practice. The Employee Educator audited the 12 hours of mandatory education requirement for all active certified nursing assistants, and all were confirmed to be compliant with the requirement. Going forward an educational requirement reminder will be broadcast through email/text monthly. Week 4 of each month, the Employee Educator will send the DON/designee an "Early Warning" list of individuals who have not yet completed the education requirement for the current month. On Week 1 of the following month, an audit will be generated noting those who have not met the educational requirement. These individuals will be removed from the active work schedule to complete the required education on their next scheduled shift. In addition, the Director of Nursing will generate a performance improvement plan addressing the failure to complete a work requirement. Continued failure to meet the monthly education completion requirements will result in disciplinary action up to and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315394	A. BUILDING _____ B. WING _____	C 02/20/2024

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

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F 947	Continued From page 27 those determined by the facility assessment." NJAC 8:39-43.17 (b)	F 947	including separation of employment. To ensure compliance, the Employee Educator will audit course completion, document findings, and report findings to the QAPI (Quality Assurance Performance Improvement) Committee monthly for three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030501	A. BUILDING: _____ B. WING _____	C 02/20/2024

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

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 2 of 5 weeks of complaint staffing reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	No residents were identified or affected by this practice. Efforts to hire community staff will continue until there is adequate staff to serve all residents. Until that time, staff working overtime shifts and contracted agency staff will be used to fill open shifts and open positions. All residents have the potential to be affected by this practice. Contracts with additional staffing agencies have been renewed and/or approved. Hiring and recruitment efforts including wage analysis and adjustments, online job listings, job fairs, shift differentials, special compensation programs, referral bonuses	3/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030501	A. BUILDING: _____ B. WING _____	C 02/20/2024

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. This deficient practice as identified for the shifts reviewed as follows: 1. For the week of Complaint staffing from 05/14/2023 to 05/20/2023, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -05/14/23 had 4 CNAs for 56 residents on the day shift, required at least 7 CNAs. -05/15/23 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. -05/16/23 had 5 CNAs for 56 residents on the day shift, required at least 7 CNAs. 2. For the week of Complaint staffing from 07/09/23 to 07/15/2023, the facility was deficient in CNA staffing for resident on 1 of 7 day shifts as follows: -07/12/23 had 6 CNAs for 55 residents on the day	S 560	and sign on bonuses are being utilized to become more competitive in the market. Weekly recruitment meetings are ongoing with an external recruiter, human resource, and the administrator. Managers, working within their scope of practice, will continue to provide assistance and support to residents until staffing requirements are met. Staffing patterns will be reviewed in daily stand up and at shift report to ensure staffing patterns are at an acceptable level. Licensed staff and certified nursing assistants will be provided in-service education on the importance of communication and notifying the Director of Nursing or Administrator if they are unable to document or meet the needs of the residents as related to staffing. A staffing variance report will be completed for each shift that does not meet required care ratios. The Social Worker will conduct a random satisfaction survey of 10 residents per month for 3 months. The data collected from the staffing variance report and resident satisfaction surveys will be documented and reported to the QAPI (Quality Assurance Performance Improvement) Committee monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030501	A. BUILDING: _____ B. WING _____	C 02/20/2024

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

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S 560	Continued From page 2 shift, required at least 7 CNAs. A review of a provided facility policy titled, "Healthcare Staffing Guidelines (RS-73), with a revised date of 3/23/2023, under "Procedure," included: The following direct care staff to resident ratios will apply for all UMC healthcare communities: -One (1) CNA to every eight (8) on day shift. -One (1) direct care staff member to every ten (10) residents for evening shift provided no fewer than half of all staff members are certified nursing aides and each direct care staff member that are scheduled to work as a certified nursing assistance (CNA) shall perform certified nursing aide duties. -One (1) direct care staff member to every fourteen (14) residents for night shift provided each direct care staff member that are scheduled to work as a certified nursing aide (CNA) shall perform certified nursing aide duties.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315394	A. Building B. Wing	4/2/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT THE SHORES	2201 BAY AVENUE OCEAN CITY, NJ 08226

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0641 Reg. # 483.20(g) LSC	Correction Completed 03/25/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315394 Y1	A. Building B. Wing Y2	4/2/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT THE SHORES	2201 BAY AVENUE OCEAN CITY, NJ 08226

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0582	Correction	ID Prefix F0641	Correction	ID Prefix F0656	Correction
Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	03/25/2024	LSC	03/25/2024	LSC	03/25/2024
ID Prefix F0658	Correction	ID Prefix F0759	Correction	ID Prefix F0809	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.45(f)(1)	Completed	Reg. # 483.60(f)(1)-(3)	Completed
LSC	03/25/2024	LSC	03/25/2024	LSC	03/25/2024
ID Prefix F0812	Correction	ID Prefix F0947	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.95(g)(1)-(4)	Completed	Reg. #	Completed
LSC	03/25/2024	LSC	03/25/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030501 Y1	A. Building B. Wing Y2	4/2/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT THE SHORES	2201 BAY AVENUE OCEAN CITY, NJ 08226

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/25/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 2/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315394	A. BUILDING **01** B. WING _____	**02/20/2024**

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

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 02/20/24. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 02/20/24 was found to be in noncompliance 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 United Methodist Communities at the Shores is a three-story building that was built in 1963, It is composed of Type II protected construction. LTC is only on the third floor. The facility is divided into three - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 56 of 60.	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be	K 321		3/29/24

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

Electronically Signed | 03/10/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315394	A. BUILDING **01** B. WING _____	R **04/02/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT THE SHORES	**2201 BAY AVENUE** **OCEAN CITY, NJ 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
{E 000}	Initial Comments	{E 000}		
{K 000}	INITIAL COMMENTS	{K 000}		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315394	A. BUILDING **01** B. WING _____	**02/20/2024**

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

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K 321	Continued From page 1 separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire rated doors from the kitchen to the dining area were equipped with fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.2.1. This deficient practice had the potential to affect all 56 residents who resided at the facility. Findings include: An observation on 02/20/24 at 12:50 PM revealed the fire rated doors leading from the kitchen to the dining area that is open to the corridor were equipped with panic hardware and not the required fire exit hardware.	K 321	The hardware on the fire rated door from the kitchen to the dining area was replaced with fire exit hardware in accordance with NFPA 101 Life Safety Code. All residents have the potential to be affected by this practice. All fire rated doors were audited to ensure appropriate hardware. Appropriate hardware will be added to the preventative maintenance schedule assigned annually. Annual fire door hardware audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315394	A. BUILDING **01** B. WING _____	**02/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 321	Continued From page 2 The[US FOIA (b)(6) redacted] was present at the time of the observation and confirmed the panic hardware was installed on the kitchen fire doors leading to the dining room. NJAC 8:39-31.2(e)	K 321	placed on the preventative maintenance calendar and audited for completion, documented and reported annually to the QAPI (Quality Assurance Performance Improvement) Committee for 1 year.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure the fire doors were inspected annually in accordance with NFPA 101 Life Safety Code (2012 edition) 7.2.1.15. This deficient practice had the potential to affect all 56 residents who resided at the facility. Findings include: A review of the facility's fire inspection binder dated for the year 2023, provided by the	K 761	The Maintenance Department inspected the fire doors for compliance with with NFPA 101 Life Safety Code (2012 edition) All residents have the potential to be affected by this practice. The fire door inspection will be added to the annual preventative maintenance schedule and the Director of Maintenance and Building Operations will ensure the	3/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315394	A. BUILDING **01** B. WING _____	**02/20/2024**

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

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K 761	Continued From page 3 US FOIA (b)(6), revealed no inspections on the facilities fire door assemblies. During an interview on 02/20/24 at 1:30 PM, the US FOIA (b)(6) confirmed the fire doors were not inspected. NJAC 8:39-31.2(e) NFPA 80	K 761	inspection is scheduled, completed, and documentation is available to confirm compliance. The Maintenance Director will place the annual fire door inspections on the preventative maintenance calendar and audit for completion. The results of these audits will be documented and reported annually to the QAPI (Quality Assurance Performance Improvement) Committee for 1 year.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315394	A. Building 01 - MAIN BUILDING 01 B. Wing	4/2/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST COMMUNITIES AT THE SHORES	2201 BAY AVENUE OCEAN CITY, NJ 08226

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 03/29/2024	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 03/29/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/20/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**