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 05/17/2023

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 000	INITIAL COMMENTS Complaint #: NJ159493, NJ163838 Census: 53 Sample: 5 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights	F 585		7/6/23

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

Electronically Signed | 06/17/2023

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.

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F 585	Continued From page 1	F 585		

contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect,

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F 585	Continued From page 2 abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: C#: NJ159493 Based on interviews, medical record review, and review of other pertinent facility documents on 5/11/2023, 5/12/2023, and 5/17/2023, it was determined that the facility failed to file a formal grievance and follow their policy titled "Resident Concerns & Grievances," after receiving a family member complaint. This deficient practice was	F 585	1. Resident # 1 is no longer in the community and a reassessment could not be performed. Newly hired social worker will be provided education on the community□s grievance policy and procedures. 2. All residents who have a concern or grievance have the potential to be affected by this cited practice. All current residents were interviewed to ensure that	

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F 585	Continued From page 3 identified for 1 of 5 residents (Resident #1) reviewed for Grievances and was evidenced by the following: Review of the Medical Record was as follows: According to the "Face Sheet," Resident #1 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted]). A review of a clinical note from the former Social Worker (SW) dated [redacted] noted that on [redacted], the former SW was approached by Resident #1's family member with multiple concerns regarding care over the weekend. The clinical note revealed the former SW and the Nurse Mentor / Registered Nurse (NMRN) met extensively with the resident's family members regarding the family's concerns. During this time, the SW and NMRN assured the family that their concerns would be checked into and addressed. The SW further noted that the complaints were documented via [through] a grievance form. On 5/11/2023 at 12:00 PM, the surveyor requested a list of grievances filed during [redacted] and [redacted] from the Director of Nursing (DON). Resident #1's name was missing from the list provided to the surveyor. On 5/12/2023 at 9:56 AM, the surveyor requested the former SW notes regarding Resident #1 from	F 585	they do not have any outstanding unaddressed concerns or grievances. No issues were identified. 3.Resident Council and all current healthcare staff will be provided in-service education on the community□s grievance policy and procedure. A Posting has been posted on the central hallway of the healthcare center identifying the grievance officer and how to submit a grievance, also a lock box has been purchased and will be centrally located in the same area. All residents and resident representatives will be provided a copy via email or mail on the grievance process to file a concern or grievance. Lock box will be checked daily for grievances and addressed by the grievance officer. Grievance concerns will be added to the stand- up meeting agenda Monday through Friday for review by the interdisciplinary team. The Social worker will be responsible for checking the grievance lock box and will provide a timely response to the concerns identified. Ongoing, the Community Life Director will announce who the grievance officer is at the beginning of every Resident Council Meeting and how to file a grievance. 4.The grievance lock box will be checked daily on business days by the social worker. All grievances identified daily will be followed up timely and the grievance log and forms shall be completed by the social worker. An audit will be conducted weekly by the Administrator of the grievance binder to ensure compliance with the community's	

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F 585	Continued From page 4 the DON. Further review of the SW notes indicated that she had filed a grievance form about the family member's complaints on [redacted]. However, during the survey, the facility could not provide any grievance form about Resident #1's family members' complaints. During an interview on 5/12/23 at 11:39 AM regarding Resident #1, the former SW recalled she knew the resident and documented information about the complaint from the family. The former SW didn't remember the specific complaint by the family. She stated, "If a complaint was initiated, it would be investigated." The SW did not recall or specify that a grievance form was filed during the interview. During an interview on 5/17/23 at 9:50 AM regarding the grievance form, the DON stated she spoke to the former SW, who told her that she did not file a grievance form on [redacted], as indicated in her progress note. The former SW told the DON that because she typed up a narrative in the progress notes with the NMRN, she felt it would be redundant to file a grievance form. According to the DON, the former SW said even though her note said she filed a grievance form; she did not actually do it. The DON stated that her expectation was if the SW said she filled out a grievance form, she should have done it. Review of the facility's policy titled "Resident Concerns & Grievances," dated 1/17/23, included the following under: "Purpose": "To respond to resident complaints related to care, treatment, or services in a manner consistent with the procedures described below...." Under: "Definitions:" included "Grievance - A grievance is any written or verbal concern by a resident,	F 585	grievance procedure and that thorough follow up documentation has been completed 100 percent. Issues identified of grievance documentation will be discussed in the daily stand up with immediate corrective action. This weekly audit process by the administrator will be an ongoing process with an initiation of a grievance until acceptable compliance is met. In addition, the administrator/designee will report findings monthly, times 3 months to the QAPI committee during the monthly QAPI meeting. The frequency of the audits by the administrator will be adjusted according to the outcomes and corrective disciplinary action will be provided as warranted.	

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F 585	Continued From page 5 relative, or any representative related to resident care or the quality of services provided." "Prompt effort to resolve include facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance." "A complaint is considered a grievance when... The complaint is communicated verbally but cannot be resolved at the time of the complaint by staff present; it requires additional time for investigation or action, or referral to other staff for sufficient resolution." Procedure - All grievances shall, whenever possible, be responded by the designated SW or responsible department manager closest to the cause of the concern/grievance; responses to resident/responsible party shall be made as soon as possible and preferably immediately; and (1) If a concern/grievance of any kind is noted, the Concern/Grievance form is used."	F 585		
F 641 SS=D	NJAC: 8:39-13.2(c) 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: C#: NJ159493 Based on interviews, medical record review, and review of other pertinent facility documents on 5/11/2023, 5/12/2023, and 5/17/2023, it was determined that the facility failed to accurately complete an Admission Assessment to reflect the resident's status and failed to follow their policy	F 641	1. Resident #1 is no longer a resident in community, care plan could not be revised, unable to correct past assessments, and resident#1 was discharged prior to need for a MDS assessment completion. The nurse mentor/register nurse (NMRN) identified will be provided inservice education on the	7/6/23

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F 641	Continued From page 6 titled "Healthcare Admission Process," for a newly admitted resident (Resident #1). This deficient practice was identified for 1 of 5 residents (Resident #1) and was evidenced by the following: Review of the Medical Record was as follows: According to the "Face Sheet (FS)," Resident #1 was admitted to the facility on [redacted], with diagnoses including but were not limited to: Subarachnoid hemorrhage (a brain bleed) [redacted]). A review of the "Skilled Nursing Admission Evaluation (SNAE)" dated [redacted] at 3:38 PM, completed by the Nurse Mentor/Registered Nurse (NMRN) for Resident #1 upon entry to the facility, showed under [redacted]" that the resident was always [redacted] Resident #1 was also noted to have an [redacted] at the time of admission. Under the section [redacted] Care," the resident was noted to have no [redacted] present at the time of admission, even though the resident had [redacted] present from the [redacted] During an interview on 5/12/23 at 10:02 AM, the NMRN, who completed Resident #1's admission assessment. She stated Resident #1 was [redacted]. The surveyor showed the NMRN the "Skilled Nursing Admission Evaluation" that noted Resident #1 also had an [redacted] [redacted] at the time of admission. The	F 641	healthcare admission process with emphasis on [redacted] management and [redacted] assessment documentation. 2. All new residents have the potential to be affected by this cited practice. An audit will be completed of all residents admitted within the past 30 days with emphasis on [redacted] and [redacted] to ensure accuracy of assessments. Issues identified will be corrected and the care plan revised accordingly and if need be the MDS will be modified. 3. All license nurses will be provided inservice education on the healthcare admission process with emphasis on [redacted] assessment and continence management. The DON will audit newly admitted and re-admitted residents' nursing admission evaluation and interim care plan within 24 -48 hours after a resident has been admitted to the community to ensure accuracy of assessment and problems identified for the resident have been care planned with the appropriate interventions. Admissions will be reviewed in daily stand up by the DON in collaboration with the MDS Coordinator to ensure accuracy of assessments and appropriate care plans have been timely initiated for problems identified. 4.A random audit will be completed by the DON weekly x4 weeks and then monthly x 3 months to ensure accuracy of healthcare admission evaluations and care plans. Issues identified will be immediately corrected and care plans revised accordingly. The DON will report	

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F 641	Continued From page 7 NMRN stated she doesn't know why Resident #1 would have an [redacted] if he was [redacted]. She further stated the resident could have had it from the hospital, but she wasn't sure. During an interview on 5/17/23 at 10:19 AM, the Director of Nursing (DON) stated the NMRN should have measured the [redacted] and noted how many [redacted] were in the [redacted] on the admission assessment form. The DON further stated the NMRN does admission assessments regularly and was aware of the procedure to complete the forms. When the surveyor asked the DON about the resident's [redacted] of being [redacted] but having an [redacted] on the admission record, the DON stated, "they come from the hospital that way sometimes." During an interview on 5/17/23 at 12:10 PM, regarding the [redacted] Care" section of the admission assessment, which indicated Resident #1 had no [redacted] at the time of admission to the facility. The surveyor showed the NMRN Resident #1 "FS" which indicated [redacted] from the injury sustained at home. The NMRN stated she should have documented in the "[redacted] Care" section the [redacted] the resident had at the time of admission. She further stated that she wouldn't have measured the [redacted]. When asked if she should have filled out the top section of the form where it noted [redacted], and [redacted] the NMRN stated she didn't know if those areas should have been filled out. She continued to say she should have documented in the [redacted] [redacted] section that Resident #1 had a laceration and the [redacted] where the [redacted] was located.	F 641	to the administrator and QAPI committee the following for the next 90 days: # of admission per month, the number of interim care plans audited against nursing admission evaluation and the percentage of care plans in compliance. The frequency of the audits will be adjusted according to the outcomes with corrective action as warranted.	

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F 641	Continued From page 8 During a second interview on 5/17/23 at 12:40 PM, the surveyor interviewed the DON about the skilled nursing admission evaluation done by the NMRN. The DON stated the NMRN should have documented the [redacted] on Resident #1's [redacted] and the [redacted] present. Review of the "Healthcare Admission Process" dated[redacted] revealed under (D) "Nursing Admission Evaluation, A head to toe assessment included the following body systems (7) genitourinary, (8) skin and (I) Wound Assessment: To be completed on the day of admission if the resident is admitted with skin changes (bruises, skin tears, pressure ulcers, etc.) and weekly until the wound is healed."	F 641		
F 656 SS=D	NJAC 8:39-11-2(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	F 656		7/6/23

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F 656	Continued From page 9 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: C#: NJ159493 Based on interviews, medical record review, and review of other pertinent facility documents on 5/11/2023, 5/12/2023, and 5/17/2023, it was determined that the facility failed to initiate a comprehensive person center care plan for a resident with [redacted] and identified [redacted] The facility also failed to follow its	F 656	1. Resident #1 is no longer a resident in community, care plan could not be revised, unable to correct past assessments, and resident#1 was discharged prior to need for a MDS assessment completion. The nurse mentor/register nurse (NMRN) identified will be provided inservice education on the healthcare admission process with	

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F 656	Continued From page 10 policy titled "Care Plan (RS-1)," dated [redacted]. This deficient practice was identified for 1 of 5 residents (Resident #1) and was evidenced by the following: Review of the Medical Record was as follows: According to the "Face Sheet," Resident #1 was admitted to the facility on [redacted], with diagnoses including but were not limited to: [redacted] Review of the "Skilled Nursing Admission Evaluation (SNAE)," dated [redacted] at 3:38 PM for Resident #1 completed by the Nurse Mentor/Registered Nurse (NMRN) upon the resident's entry into the facility, showed Resident #1's [redacted] but also noted the resident came in with an [redacted]). Review of the nursing progress notes (NPNs) for Resident #1 revealed the resident was [redacted] of [redacted] and [redacted] The Physician's admission note dated [redacted] also identified the resident as [redacted] The surveyor reviewed a written statement from the Certified Nursing Assistant (CNA) who cared for Resident #1. The CNA's statement indicated the resident wasn't wearing [redacted] when he entered the facility. The CNA wrote that the next day after admission, the resident's bed	F 656	emphasis on urinary continence management and head to toe skin assessment documentation. 2. All new residents have the potential to be affected by this cited practice. An audit will be completed of all residents admitted within the past 30 days with emphasis on [redacted] assessment to ensure accuracy of assessments. Issues identified will be corrected and the care plan revised accordingly and if need be, the MDS will be modified. 3. All license nurses will be provided inservice education on the healthcare admission process with emphasis on [redacted] assessment and [redacted] management. The DON will audit newly admitted and re-admitted residents' nursing admission evaluations and interim care plans within 24 -48 hours after a resident has been admitted to the community to ensure accuracy of assessments, and problems identified for the resident have been care planned with the appropriate interventions and that the resident's summary reflects the resident's care needs for the problems identified. All admissions will be reviewed in daily stand up by the DON in collaboration with the MDS Coordinator to ensure accuracy of assessments and appropriate care plans have been timely initiated for problems identified. 4.A random audit will be completed by the DON weekly x4 weeks and then monthly x 3 months to ensure accuracy of healthcare admission evaluations and care plans. Issues identified will be immediately corrected and care plans	

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F 656	Continued From page 11 [redacted] The CNA explained to the resident the need to [redacted], and the resident was "okay with that." The surveyor reviewed the Licensed Practical Nurse (LPN #1) statement dated [redacted] and [redacted] which indicated the CNA provided [redacted] due to the resident being [redacted]. The surveyor reviewed another statement from a second LPN (LPN #2) dated [redacted], which indicated LPN #2 answered the resident's call light, the resident's [redacted] told LPN #2 the resident needed to use the bathroom and/or be "[redacted] Review of the Care Plan dated [redacted] revealed Resident #1 had no care plan in place for [redacted] or a [redacted] after it was identified by the doctor and nursing staff. During an interview on 5/17/23 at 10:19 AM, the Director of Nursing (DON) stated that urinary incontinence should be on the resident's care plan. She looked at the care plan for Resident #1 and indicated that she did not see the resident care plan for [redacted]. The DON explained that "The resident should have been care planned after he/she was identified as [redacted]." She further stated that the Minimum Data Set (MDS) Coordinator would be responsible for making sure the resident was care planned for [redacted]. At the time of the survey, the Minimum Data Set (MDS) Coordinator was unavailable for an interview.	F 656	revised accordingly. The DON will report to the administrator and QAPI committee the following for the next 90 days: # of admission per month, the number of interim care plans audited against nursing admission evaluation and the percentage of care plans in compliance. The frequency of the audits will be adjusted according to the outcomes with corrective action as warranted.	

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 05/17/2023

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 656	Continued From page 12 A review of the facility policy "[redacted] Management," dated 3/8/22, under "Skilled Healthcare Procedure, The care plan and the resident's summary will be updated to reflect the resident's individualized [redacted] needs and the appropriate [redacted] management program." A review of the policy "Care Plan" under "Purpose - to guide the care and treatment provided to each resident; 16. The RN MDS Coordinator is responsible to ensure that each portion of the care plan is updated; 17. The care plan process is part of a dynamic cycle: evaluation of resident care is followed up by a re-assessment of resident needs to determine whether or not the plan of care requires modification. This process is completed whenever the resident's condition changes; 18. The Care Plan is to reviewed and updated by all staff providing care or services for the resident." NJAC: 8:39-11.2(i)	F 656		
F 690 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	F 690		7/6/23

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 05/17/2023

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 690	Continued From page 13 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: Complaint#: NJ159493 Based on interviews, medical record review, and review of other pertinent facility documents on 5/11/2023, 5/12/2023, and 5/17/2023, it was determined that the facility failed to provide evidence that incontinence care was consistently provided to Resident #1. The facility also failed to follow its policies titled "[redacted] Incontinence Management" and "Activities of Daily Living." This practice was identified for 1 of 5 residents (Resident #1) and evidenced by the following: Review of the medical record is as follows: According to the "Face Sheet (FS)," Resident #1 was admitted to the facility on [redacted], with	F 690	1. Resident #1 is no longer in the community. 2. All current residents and newly admitted residents with incontinence and devices have the potential to be affected by this cited practice. 3.All current certified nursing assistants will be provided in-service education by the resident service staff educator on importance of completion of ADL and resident care documentation. The charge nurse on duty will be responsible for ensuring documentation is completed each shift. The DON/ Nurse Mentor will review the point of care documentation dashboard daily to ensure compliance. Findings will be reviewed, and corrective	

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 05/17/2023

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 690	Continued From page 14 diagnoses including but were not limited to: [redacted] A review of the "Skilled Nursing Admission Evaluation (SNAE)" completed by the Nurse Mentor/Registered Nurse (NMRN) for Resident #1 on [redacted] at 3:38 p.m. indicated Resident #1's [redacted] status as [redacted] with an [redacted]. According to the nursing progress notes (NPN), documented by the Registered Nurse (RN), dated [redacted] at 3:45 p.m., Resident #1 was [redacted]. Further review of the NPN revealed other [redacted] episodes on [redacted] and [redacted]. The physician admission note dated [redacted] also identified Resident #1 as [redacted]. A review of the Activities of Daily Living (ADLs) Verification Worksheet from [redacted] through [redacted] revealed blank spaces, which indicated the task was not documented as being completed as follows: On 10/27/22, on the day (7:00 a.m.-3:00 p.m.) and evening (3:00 p.m.-11:00 p.m.) shift was blank. On 10/28/22, on the night shift (11:00 p.m.-:7:00 a.m.)shift was blank. On 10/29 /22, on the 7:00 a.m.-3:00 p.m. and the 3:00 p.m.-11:00 p.m. shift was blank. On 10/30/22, on the 7:00 a.m.-3:00 p.m. and the	F 690	disciplinary action as warranted. Ongoing education will be provided during on-boarding of new direct care givers by the resident service staff educator to ensure compliance with ADL and resident care documentation. 4. DON/ADON will randomly audit, by visual observation of point of care dashboard of care documentation for 10 residents per week to verify care is rendered and properly documented. Audits will be conducted weekly for 12 weeks. Areas of concern will be addressed. Results of these audits will be reviewed at the monthly Quality Assurance Performance Improvement meeting each month for the next three months with immediate corrective disciplinary action as warranted.	

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 05/17/2023

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UNITED METHODIST COMMUNITIES AT THE SHORES	2201 BAY AVENUE OCEAN CITY, NJ 08226

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F 690	Continued From page 15	F 690		

3:00 p.m.-11:00 p.m. shift was blank.
On 10/31/22, 7:00 a.m.-3:00 p.m. and the 3:00 p.m.-11:00 p.m. shift was blank.
On 11/1/22, on the 7:00 a.m.-3:00 p.m. shift was blank.

During an interview on 5/17/23 at 11:25 a.m., the surveyor reviewed the aforementioned blank spaces with the Director of Nursing (DON). The DON acknowledged the blank spaces. She stated, "We have a problem with [the] documentation of ADLs. The DON continued that if the resident refused care, there is a column the staff can document the refusal, but none were noted on the form. She further stated the Certified Nursing Assistants (CNAs) didn't document the care given to Resident #1. The CNAs should have documented every time the resident was [redacted].

During an interview on 5/17/23 at 11:40 a.m., the CNA stated she checked the resident's [redacted] and would ask the residents if they needed to be changed at the start of her shift and as needed throughout the shift. The CNA stated she would change all residents, then go into the computer and document after all residents were changed, not after each resident.

During a second interview on 5/17/23 at 12:40 p.m., the surveyor interviewed the DON, who presented a timeline [redacted] care that was not provided for Resident #1. The DON stated, on days without documentation, "I don't know if care was done." If it's not documented, it's not done." The DON said the CNAs should have provided care and then immediately documented that care was given.

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 05/17/2023

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 690	Continued From page 16 Reviewed of the facility's policy titled [redacted] Management (RS-11), dated 3/8/23, which noted under "Purpose - to ensure that residents who are [redacted] receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal [redacted] function as possible; and To ensure that each resident who is incontinent of urine is identified, assessed upon admission and is provided appropriate treatment through a systematic person centered approach to assist the resident to regain [redacted] upon recovery from a significant change in functional status; "Special Instructions: [redacted] trial; Definitions of types of [redacted] when the [redacted] has reached maximum capacity; under "Skilled Healthcare Procedure: A [redacted] management program will be implemented based on the resident's - specific reason for incontinence, individual goals, and the schedule for toileting, as well as special concerns." Review of the facility's policy titled "Activities of Daily Living," dated 7/22/20, which noted under "c. other functional communication systems, A resident who is unable to carry out activities of daily living will receive necessary services to maintain grooming..., The direct care giver is responsible for documentation of the ADLs each shift, whether through paper or electronic documentation...and, The Certified Nursing Assistants (CNAs) are responsible for completing the ADL data in the kiosk or tablets each shift, however, it remains the DON/Nurse Designee and the MDS Coordinator's responsibility to check for accuracy and daily completion of ADLs."	F 690		

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 05/17/2023

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 690	Continued From page 17 NJAC-8:39 27.1(a)	F 690		

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 05/17/2023

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 COMPLAINT#: NJ159493, NJ163838 Census: 53 Sample: 5 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: C#: NJ159493, NJ163838 Based on interview and review of pertinent 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 was evident for 1 of 14 nursing shifts reviewed for 10/23/2022 to 11/5/22 and 5 of 14 nursing shifts reviewed for	S 560	1.No residents were identified or affectedby this cited practice. Efforts to hire community staff will continue until there is adequate staff to serve all residents. Until that time, community will utilize staffing agencies, offer overtime to community staff to fill any open spots in the schedule.	7/6/23

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

Electronically Signed | 06/17/23

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 05/17/2023

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S 560	Continued From page 1 04/23/2023 t0 05/06/2023 in a two week period for the facility: 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 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. As per the "Nurse Staffing Report" completed by the facility for the weeks of 10/23/2022 to 11/05/2022 and 04/23/2023 to 05/06/2023 the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift are documented below: 1. For the 2 weeks from 10/23/2022 to 11/05/2022, the facility was deficient in CNA	S 560	2. All residents have the potential to be affected by this cited practice. 3. Contracts with additional staffing agencies have been secured to supplement community staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace. Weekly recruitment meetings are ongoing with the home office, executive director, nursing home administrator and the associate resource director. Education will be provided to the staff regarding call offs and how it affects the community, the residents', and their peers by the resident service staff educator and the DON as needed. Managers to provide assist as applicable based on job training and qualifications to support nursing until staffing requirements are met. Staffing patterns will be reviewed in the daily stand up and shift report to ensure staffing patterns are at acceptable level. The administrator will communicate with families monthly to make them aware of staffing patterns and recruitment efforts until staffing stabilizes. License staff and certified nurse aides will be provided in-service education on the importance of communication and notifying the DON (Director of Nursing)or Administrator if they are unable document or to meet the needs of the residents related to staffing. The community census will be adjusted by temporarily suspending admissions to meet staffing requirements as needed.	

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 05/17/2023

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 staffing for residents on 1 of 14 day shifts as follows: 10/23/23 had 6 CNAs for 53 residents on day shift, required 7 CNAs. 2. For the 2 weeks from 04/23/2023 to 05/06/2023, the facility was deficient in CNA staffing for 5 of 14 day shifts as follows: 04/23/2023 had 6 CNAs for 54 residents on the day shift, required 7 CNAs. 04/24/2023 had 6 CNAs for 54 residents on the day shift, required 7 CNAs. 04/25/2023 had 6 CNAs for 54 residents on the day shift, required 7 CNAs. 04/29/2023 had 6 CNAs for 53 residents on the day shift, required 7 CNAs. 05/04/2023 had 6 CNAs for 53 residents on the day shift, required 7 CNAs. NJAC 8:39-5.1(a)	S 560	4. The Administrator and the DON (director of nursing) will review staffing schedules daily as part of the daily standup meeting to ensure adequate staffing for all shifts. The administrator and the Associate Resource Director (HR) will continue to review recruitment and staffing weekly. This will remain an ongoing practice until staffing requirements are maintained. The social worker will conduct a random resident satisfaction survey of care monthly x 3 months and then quarterly as it relates to staffing challenges to ensure resident care needs continue to be maintained. The results of the daily staffing reviews and resident satisfaction surveys will be submitted to the monthly and quarterly QAPI committee through the remainder of 2023 with a supportive corrective action plan. All findings from the daily staffing and resident satisfaction reviews will continue to be reviewed with the QAPI (Quality assurance performance and Improvement) committee until staffing requirements meet state requirements consistently.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030501 Y1	A. Building B. Wing Y2	7/11/2023 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 07/06/2023	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 5/17/2023	☐ 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	7/11/2023 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 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 F0585	Correction	ID Prefix F0641	Correction	ID Prefix F0656	Correction
Reg. # 483.10(j)(1)-(4)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	07/06/2023	LSC	07/06/2023	LSC	07/06/2023
ID Prefix F0690	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/06/2023	LSC		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	
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/17/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
030501		7/11/2023

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 07/06/2023	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	
5/17/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO