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

PRINTED: 10/24/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	085037		09/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

(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) COMPLETE DATE
F000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from September 12, 2017 through September 20, 2017. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 163. The stage two survey sample was 36. Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; NP-Nurse Practitioner; RDO-Regional Director of Operations; WCN-Wound Care Nurse; AIMS (Abnormal Involuntary Movement Scale) - test to measure body movements the resident cannot control, which can be a side effect of antipsychotic medications; Air mattress-pressure relieving mattress; Antipsychotic - drug to treat psychosis and other mental/emotional conditions (i.e., Zyprexa); Anxiety - feeling worried, nervous or restless; Aspirate - withdraw fluid; Ativan - drug to treat anxiety; Ausculatory - listening; Cognitively Intact - able to make own decisions; Contracture - joint with fixed resistance to passive stretch of a muscle and cannot	F000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Johnson, Administrator — TITLE: Electronically Signed 10/24/2017 — (X6) DATE: 10/11/2017

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 the 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.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. The electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	0B5037		09/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

(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) COMPLETE DATE
F000	Continued From page 1 straighten; Centimeter (cm) - a metric measurement of length; 1 centimeter = 0.39 inches; Delusion - false belief that is thought to be true; Dementia - severe state of cognitive impairment characterized by memory loss, poor judgement, disorientation and personality changes; Depakote - medication to improve mood; Depression - mood disorder with feelings of sadness; eMAR - Electronic Medication Administration Record (in the computer); EPS (Extrapyramidal Symptoms) - involuntary movements from psychoative drugs; eTAR - Electronic Treatment Administration Record (in the computer); Friction - rubbing that causes injury to the skin; Gastric - stomach; Gastrostomy Tube (GT) - a tube inserted through the abdomen into the stomach; GDR (Gradual Dose Reduction) - slowly reducing amount of medication; i.e. - that is; Granulation - new tissue with blood vessels formed during wound healing; Hallucinations - something that seems real but does not really exist; Heel Protectors - pressure reducing device for feet; Low-air-loss mattress - circulating air within mattress to reduce pressure on skin/muscle; MDS (Minimum Data Set) - standardized assessment used in nursing homes; mL (milliliter) -unit of liquid volume, 5 ml equals 1 teaspoon; mg (milligram) -unit of weight, 1 mg equals 0.0035 ounce; MTP (Metatarsophalangeal) - toe joints at the ball of the foot: 1st is at the large toe and 5th is at the little toe; OT - Occupational therapy;	F000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F000	Continued From page 2 Paranoid - mental illness that causes you to falsely believe people are trying to hurt you; PASRR (Pre-Admission Screening and Resident Review) - federally mandated screening to identify those with mental illness or intellectual disability to determine if specialized services are needed in the nursing home; Pre - before; Pressure Injury Severity Rating: - Stage 1 Pressure Injury: Intact red skin often over a boney area that does not turn white / light (does not blanche) when pressed; which may appear differently in darkly pigmented skin. - Stage 2 Pressure Injury: Blister or shallow open sore with red/pink color. Deeper tissues/fat, granulation tissue, slough and eschar are not present. - Stage 3 Pressure Injury: Open sore that goes into the tissue under below the skin. How deep it is depends on the amount of tissue under the skin. Fat, granulation tissue and rolled edges are often present. Little slough and/or eschar may be visible but does not hide the extent of tissue loss. - Stage 4 Pressure Injury: Open sore so deep that muscle, tendons, ligaments, cartilage or bone can be seen. Rolled edges, undermining, tunneling often occur. Slough or eschar may be visible. - Unstageable: Actual depth of the ulcer cannot be determined due to the presence of slough (yellow, tan, gray, green or brown soft dead tissue) and/or eschar (hard dead tissue that is tan, brown or black. Eschar is worse than slough. Once slough/eschar removed, a Stage 3 or 4 injury will be revealed. Stable eschar (i.e. dry, adherent, intact without redness or movement) on the heel or limb with impaired blood flow should not be softened or removed. - Deep Tissue Pressure Injury (DTI): Intact or non-intact deep red, maroon, purple	F000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F000	Continued From page 3 discoloration that does not turn white/light when pressed or skin separation revealing a dark wound bed or blood filled blister. Pain and temperature change often appear before skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. PRN - As needed; Post - after; pH-used to specify the acidity of a solution; PPD- skin test for tuberculosis[lung infection] Psychiatric - [Psych] - treatment of mental disorders; Psychosis/psychotic - loss of contact with reality; Psychoactive - medications that treat mental/emotional conditions; Psychotropic - drug to treat psychosis and/or other mental/emotional conditions; PT - physical therapy; Risperdal - antipsychotic drug. ROM (Range of Motion) - extent to which a joint can be moved safely; Shearing - reduced blood flow to the tissue under the skin; Silver Alginate - highly absorbant dressing that reduces bacteria/germs; Slough - yellow, tan, gray, green or brown dead tissue; Supine - lying on back; Suction - removal of fluids from the trach; Tardive dyskinesia - side effect of psychoactive drugs causing stiff jerky movements; %-percent; MOM-milk of magnesia; Dulcolax-laxative; Enteral-involving or passing through the intestines;	F000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER: ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F000	Continued From page 4 Fleets enema-used for constipation; Trach - tracheostomy-an opening made in the throat to assist breathing.	F000		
F164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at 483.70(i)(2) or other applicable federal or state laws. 483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the residents records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F164	A. E9 was educated regarding privacy and confidentiality/proper procedure before entering R5's room. B. E9 will be observed by Staff Dev. /Designee regarding privacy and confidentiality/proper procedure before entering residents room. C. All staff will be in-serviced by Staff Dev/Designee regarding privacy and confidentiality/proper procedure before entering residents room. D. Daily audit on all shifts by UM/Designee to ensure staff are respecting residents privacy until a 100 % compliance x 7 days is achieved, followed by a weekly audit x 4, then monthly through the next quarter. Reports will be submitted to QA monthly.	11/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F164	Continued From page 5 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that the facility failed to ensure privacy for one (R5) out of 36 sampled residents. Findings include: During a dressing change on 9/19/17 at 10:09 AM E9 (OT) entered R5's room without receiving permission to enter. When E9 was asked to leave and return later by E8 (WCN), E9 responded in a loud and stern voice and insisted E8 stop R5's wound care and answer questions relating to another resident. During an interview on 9/19/17 at 10:21 AM with E8 it was confirmed that E9 interrupted R5's wound care to "ask me when I was coming to see a resident on another unit." During an interview on 9/19/17 at 10:58 AM with E9 it was confirmed that she entered R5's room without knocking and insisted E8 speak with her about another resident. E9 explained "I knocked the first time and I heard E8 say to come back later, I came a second time because I needed an answer." These findings were reviewed with E1(RDO), E2 (NHA) and E3 (DON) on 9/20/17 at 2:45 PM	F164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F164	Continued From page 6 during exit conference.	F164		
F272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a residents needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct	F272	A. E19 was educated on correct coding for pressure ulcers. R218s MDS was modified. E19 was educated on the correct coding for suctioning of trach. R232s MDS was modified. B. All active residents with pressure ulcers will be audited for accuracy of coding of pressure ulcers. All active residents with tracheostomy will be audited for accuracy of coding for suctioning. C. All Registered Nurse Assessment Coordinator (RNACs) will be in-serviced by corporate RNAC on accurate coding of pressure ulcers and tracheostomy suctioning. D. Weekly audit of all assessments of residents with pressure ulcers will be audited until 100% compliance x3 is achieved, followed by a monthly audit through next quarter. Report will be submitted to QA monthly. Weekly audit of all assessments of residents with tracheostomy tube until 100% compliance is achieved x 3, followed by a monthly audit through the next quarter. Report will be submitted to QA committee monthly.	11/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F272	Continued From page 7 observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to accurately assess two (R218 and R232) out of 36 sampled residents on their comprehensive assessment. Findings include: 1. Review of R218's clinical record revealed: 6/8/17 - Wound assessment note documented R218 had a left heel DTI and an unstageable pressure injury of the 5th MTP. 6/13/17 - Significant Change MDS assessment incorrectly assessed the resident as having 2 DTIs and one unstageable pressure ulcer. During an interview with E19 (RNAC) on 9/20/17 at 10:52 AM E19 confirmed the error. 2. Review of R232's clinical record revealed: 6/6/17 - Annual MDS assessment documented the resident had a trach and was not suctioned. Review of the eTAR from the 14-day look-back period found the resident was suctioned.	F272		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F272	Continued From page 8 9/2/17 - Quarterly MDS assessed R232 as not receiving trach care or suctioning. Review of the eTAR found the resident received trach care and was suctioned during the 14 day look-back period. During an Interview with E19 (RNAC) on 9/20/17 around 12:45 PM the errors were confirmed. These findings were reviewed with E1(RDO), E2 (NHA) and E3 (DON) on 9/20/17 at 2:45 PM during exit conference.	F272		
F279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the residents active record and use the results of the assessments to develop, review and revise the residents comprehensive care plan. 483.21 (b) Comprehensive Care Plans (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	F279	A. R32 PASRR care plan was revised to reflect the intervention for monthly psychiatry review and supportive counseling. R218 care plan goal was revised to include the goal for signs of improvement or healing. B. All residents with Level II PASRR will be reviewed and care plan will be revised to include specific recommendations. All active residents care plan for pressure ulcers will be reviewed and revised to reflect goals for signs and symptoms of healing and improvement. C. Social Services will be in-serviced by Staff Dev/Designee regarding care planning for residents with Level 11 PASSR to include specific recommendations. Licensed staff will be in-serviced by Staff Dev./Designee on pressure ulcer care planning goals. D. Weekly audit of new residents with Level 11 PASRR until 100% compliance x 3 is achieved, followed by a monthly audit	11/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F279	Continued From page 9 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 residentâ medical record. (iv)In consultation with the resident and the residentâ representative (s)- (A) The residentâ goals for admission and desired outcomes. (B) The residentâ preference and potential for future discharge. Facilities must document whether the residentâ 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to develop an	F279	of any new Level II PASRR residents through the next quarter. Reports will be submitted to QA monthly. Weekly audit by Wound Nurse/Designee to ensure all new pressure ulcerâ care plans include goals for signs and symptoms of healing and improvement until a 100% compliance x 3 is achieved, followed by a monthly audit through the next quarter. Reports will be submitted to QA committee monthly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F279	Continued From page 10 individualized comprehensive care plan based on identified needs with measurable goals for two (R32 and R218) out of 36 sampled residents. Findings include: 1. Review of R32's clinical record revealed the following: 3/31/17 - R32's PASRR Level II (2) Determination of Mental Illness Recommendation documented that R32 required special services. The recommended services included that a psychiatrist was to review R32's mental health condition and assess R32's mental health needs on at least a monthly basis and supportive counseling was to be provided by a licensed mental health provider. Review of R32's current PASRR care plan initiated 7/5/17 with a goal that R32 will receive individualized services and supports (also known as specialized services as required to individual) to reach and maintain the highest quality of life possible in accordance with the level II determination x 90 days and will reside in the least restricted environment and have access to transition services in accordance with the resident's goals and preferences. The intervention for this care plan was case management. Neither the goals nor the intervention addressed R32's specific need for monthly psychiatry reviews and supportive counseling. During an interview on 9/19/17 at 3:05 PM with E10 (SW) it was confirmed that E10 (SW) initiated the PASRR care plan for R32 and that individualized identified needs based on the Level II recommendations were not addressed.	F279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F279	Continued From page 11 Cross Refer F282 2. Review of R218's clinical record revealed: 4/10/17 - Care plan problem for actual pressure injury included the goals to show no signs of infection and that pain will be relieved to a tolerable level. Interventions included administer pain medication and treatments; monitor for signs of infection, offload pressure to affected area. Care plan goals did not include showing signs of improvement or healing. 6/23/17 - Wound Assessment note documented the resident was on a special air mattress. 9/12/17 - Resident observed to be on an air mattress. The care plan did not include the air mattress as an intervention. During an interview with E18 (UM) on 9/20/17 at 9:15 AM E18 confirmed the missing intervention. These findings were reviewed with E1(RDO), E2 (NHA) and E3 (DON) on 9/20/17 at 2:45 PM during exit conference.	F279		
F282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care.	F282	A. R218 wound documentation was amended on 9/19/17. NP consultant no longer works for the facility. B. All active residents with pressure ulcers seen by contracted consultant within the last week will be reviewed for accuracy by facility wound nurse/designee. C. Contracted company will in-service consultant regarding accuracy of documentation submitted to facility. D. Weekly audit by facility wound nurse/designee to ensure accuracy of	11/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F282	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to accurately assess pressure ulcers for one (R218) out of 36 sampled residents. Findings include: Review of R218's clinical record revealed: 3/8/17 - Resident transferred from another nursing home with a history of a leg blood clot, dementia and leg contractures. 4/6/17 - Wound Assessment note from an outside company documented two pressure injury wounds categorized as DTIs: left heel and left 5th MTP (area on outside of foot below little toe). R218 had no pulses in either foot. The left heel wound was a purple / maroon blood blister measuring 2 cm x 3 cm. The 5th MTP wound was purple measuring 1.1 cm x 1.5 cm. Interventions currently in place included bilateral heel protectors and pressure reduction mattress. May - September 2017 - Review of pressure ulcer assessment documentation from the outside company found no evidence in the record that the resident's wounds were assessed during the week of June 9, 2017. The DTI of the left heel was resolved by 6/23/17. Two assessments of the 5th MTP labeling the wound as unstageable were not accurate since the wound depth was visible with the wound bed containing mostly granulation (healthy) tissue: - 8/23/17: 95% granulation, 1.5 x 1.5 x 0.1 - 8/30/17: 100% granulation, 1.5 x 1.5 x 0.1 During the staff interview with E18 (UM) on 9/13/17 at 10:26 AM when asked, "Does the resident currently have one or more pressure	F282	wound staging until 100% compliance x 3 is achieved, followed by a monthly audit through the next quarter. Reports will be submitted to QA committee monthly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

PRINTED: 10/24/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F282	Continued From page 13 ulcers?", E18 responded "a DTI." (R218's wound was actually a Stage 4 and not a DTI). During an interview with E8 (WCN) on 9/18/17 around 11:00 AM to discuss the missing June assessment and inaccurate staging of the 5th MTP on the August 23 and 30 assessments by the outside company, E8 stated s/he would contact this company. During an interview with E8 on 9/19/17 at 7:03 AM E8 said the NP "changed the 8/30 note but would not change the week before 23rd since there was still slough." [there was only 5% slough]. The wound care nurse provided a copy of the missing June and amended 8/30/17 wound assessments. These findings were reviewed with E1(RDO), E2 (NHA) and E3 (DON) on 9/20/17 at 2:45 PM during exit conference. During an interview with E3 on 9/20/17 around 3:35 PM, E3 confirmed that a wound could be staged with 95% - 100 % granulation tissue.	F282		
F309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the residents' comprehensive assessment and plan of care. 483.25 Quality of care	F309	A. R209's bowel movement record was reviewed in the last week with documented bowel movement at least every 3 days. B. Daily report for residents with no bowel movements for at least 3 days will be run and facility BM protocol initiated as needed. C. Licensed staff will be in-serviced by Staff Dev/Designee on compliance of facility BM protocol. D. Daily audit on compliance of facility BM protocol will be conducted until 100%	11/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F309	Continued From page 14 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents'choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents'goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents'goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed provide care in accordance with the person centered care plan, specifically to administer an ordered laxative after three days without a bowel movement for one (R209) out of 5 sampled residents for medication review. Findings include: Review of R209's clinical record revealed: 9/20/15 - Physicians' orders included several medications (laxatives) to manage the resident's constipation:	F309	compliance x 7 days is achieved, followed by a weekly audit x 4, then a monthly audit through the next quarter. Reports will be submitted to QA committee monthly	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F309	Continued From page 15 - MOM every 72 hours PRN. - Dulcolax 2 tablets orally once daily PRN. - Fleets enema once daily PRN. 9/23/15 - Care plan problem for risk for constipation related to decreased mobility included the goal that R209 will have a normal bowel movement [BM] at least every 3 days. 3/7/17 - Physicians' orders included a stool softener to be given twice a day. 6/13/17 - Physicians' orders included Miralax to be given every other evening for constipation. Review of CNA documentation (May through September 2017) of R209's bowel movements, eMAR for PRN medications and nursing notes found two instances when a PRN laxative was not administered after R209 went 3 days without a BM: - 7/5/17: R209 had a BM on July 1 (day shift) then no BM on July 2, 3, 4, 5, 6 and 7. A PRN laxative should have been given on July 5. On 7/7/17 MOM was given at 9:17 AM and Dulcolax tablets at 4:30 PM but neither were effective. R209 required an enema (7/8/17 at 6:35 AM) in order to have a bowel movement as the resident went 6 days without a BM. - 9/9/17: R209 had a BM on September 5 (day shift) then no BM on September 6, 7, 8 and 9. A PRN laxative should have been given on September 9. The eMAR revealed no laxative was administered in September, however R209 did have a BM on the 10th. During an interview with E6 (UM) on 9/20/17 at 9:35 AM E6 confirmed the September finding and later at 10:05 AM the July finding was confirmed.	F309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F309	Continued From page 16 These findings were reviewed with E1 (RDO), E2 (NHA) and E3 (DON) on 9/20/17 at 2:45 PM during exit conference.	F309		
F314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide pressure ulcer care in a manner that prevents infection for one (R218) out of 36 sampled residents. Findings include: Review of R218's clinical record revealed: 8/9/17 - Physician orders included wound care treatment to 5th MTP: Cleanse with wound cleanser; Apply silver alginate dressing and border foam to wound daily and PRN.	F314	A. E8 was educated by Staff Dev. on pressure ulcer care procedure to prevent infection on 9/18/17 after the wound care observation for R218. B. E8 will be observed by Staff Dev. to ensure compliance with pressure ulcer care in a manner that prevents infection to all residents with pressure ulcers. C. Licensed staff will be in-serviced by Staff Dev./Designee on pressure ulcer care to prevent infection/proper dressing change procedure. D. Daily wound observation will be conducted by Staff Dev/Designee to ensure staff is complaint with proper wound dressing until 100% compliance x 7 days is achieved, followed by a weekly audit x 4, then a monthly through the next quarter. Reports will be submitted to QA committee monthly.	11/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER: ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F314	Continued From page 17 9/18/17 (10:35 AM) Wound Care Observation - After removing R218's dressing from the left foot, E8 (WCN) performed hand hygiene and donned clean gloves. The nurse reached into his/her pocket with the gloved left hand to retrieve a pen and placed it on the table. E8 then used the now contaminated left hand to pick up silver alginate dressing and placed it on the foam with boarder dressing before applying it on R218's foot. During an interview with E8 immediately after wound care, the left hand contamination was confirmed. These findings were reviewed with E1 (RDO), E2 (NHA) and E3 (DON) on 9/20/17 at 2:45 PM during exit conference.	F314		
F322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration	F322	A. E17 was educated on 9/21/17 on gastric feeding tube placement verification prior to medication administration and nutrition formula for R232. B. Staff Dev/Designee will observe E17 and other staff on all units to ensure compliance with gastric feeding tube placement verification prior to medication administration and nutrition formula for all residents with gastric tube feeding. C. Policy and Procedure for Gastric Tube Placement verification and medication administration will be revised. Licensed staff will be in-serviced on revised policy and procedure on Gastric tube placement verification prior to medication administration and nutrition formula. D. Daily staff observation by Staff Dev.	11/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F322	Continued From page 18 pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. 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 verify gastric feeding tube placement prior to the administration of medications and nutrition formula for one (R232) out of 36 sampled residents. The facility also failed to take measures to minimize the amount of air entered through the tube into the resident's stomach. Findings include: 2009 - American Society for Parenteral and Enteral Nutrition Practice Recommendations included: In adult patients, do not rely on the ausculatory method to differentiate between gastric, respiratory and small bowel placement; Assure the feeding tube is in proper position before initiating feedings. Facility nursing policy entitled Confirming Placement of Feeding Tubes (Revised December, 2011) listed steps for confirming placement of a feeding tube: - Observe for a change in external tube length marked at the time of initial insertion x-ray. - Observe for signs of respiratory distress (if applicable). - Use auscultory method (Do not rely on this as a singular method) by injecting 10 mL air while listening with a stethoscope around 3 inches below the sternum (chest bone) for the "whoosing" sound. - Check pH of aspirate. February, 2009 - Facility pharmacy policy	F322	/Designee on gastric tube placement verification and medication administration until a 100% compliance x 7 days is achieved, followed by a weekly audit x 4, then a monthly through the next quarter. Reports will be submitted to QA committee monthly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F322	Continued From page 19 entitled Medication Administration: Administration of Medications by Enteral Route (revised March 2014) included the following actions to determine placement and minimize amount of air entering the stomach: - Listen to resident's abdomen below the sternum with a stethoscope while instilling 10 mL air. - Draw back on the syringe for gastric content - implies tube is patent and in the stomach. - Each medication should be administered separately, followed by a small amount of water, to prevent clogging. - Administer medications by gravity using a syringe. - Tube is crimped between each addition. December, 2011 - facility nursing policy entitled Checking Gastric Residual Policy (revised 2/23/17) included to attach a 60 mL syringe to withdraw and measure stomach contents. Hold the feeding if greater than 150 mL. Review of R232's clinical record revealed: 8/18/17 - Physicians' orders included Osmolite 1.5 (name of feeding formula) by GT: 2 containers (474 mL) three times a day and 1 container (237 mL) on night shift. Water flush 60 mL before and after bolus feeding. 8/28/17 Diet Note - Osmolite 1.5 two cans three times a day and 1 can at midnight to help with complaint of hunger, provides 1659 calories meeting more than 100% needs. Resident reports of wanting to eat food. Extra can of formula did not help. Will consider decrease of tube feeding if weight gain continues. 9/19/2017 (9:03 AM) - Observation of E17 (LPN) administering medication and a feeding. R232	F322		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F322	Continued From page 20 was seated around 60 degrees in bed. E17 instilled around around 15 mL of air and listened for the "whoosing" sound with a stethoscope. Since the resident's trach was making gurgling sounds which interfered with hearing the "whoosh" E17 suctioned the upper airway then repeated the procedure of instilling around 15 mL of air while listening below the sternum. The nurse had prepared seven medications (1 liquid and 6 crushed tablets, each mixed with water in a separate medicine cup) for administration. The nurse poured contents of the first medicine cup into the syringe attached to the GT then added 5-15 mL of water to the medication cup and stirred with a spoon to remove residual crushed medication from the cup. Water (5-10 mL) was again added to the medication cup then poured into the syringe to rinse the tube. The nurse repeated the procedure for each of the other six medications. The nurse allowed the liquid to flow completely out of the syringe (permitting air to enter the tube) after each time a medication and/or water was poured into the syringe. After all medications were instilled E17 proceeded to administer two containers of tube feeding formula. When R232 coughed, the nurse crimped (pinched) the feeding tube to prevent reflux of stomach contents into syringe and overflow the syringe. After the formula was complete, E17 flushed the tube with 120 mL of water to clear the tube. During an interview with E2 (NHA) and E3 (DON) on 9/20/17 at 9:45 AM when asked about the process for verifying GT placement, E3's response was to inject air and listen. Surveyor explained that policy stated listening should not solely be used. E2 added "We don't have pH strips. We are in the process of changing policies." E2 added that checking for gastric	F322		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F322	Continued From page 21 contents is an additional method. Informed that during observation the presence of gastric contents or measuring any residual did not occur with the observed feeding. Surveyor relayed about medication administration and how all liquids flowed thru the tube permitting air into the tube and that the tube was not pinched until R232 coughed. These findings were reviewed with E1(RDO), E2 and E3 on 9/20/17 at 2:45 PM during exit conference.	F322		
F329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that–	F329	A. R245 licensed nurses were educated on to ensure accurate documentation of behavior when prn Ativan is administered. R107's Valproic acid level was obtained on 9/20/17. R279's AIMS was completed on 9/15/17. B. Residents who received prn anti-anxiety medications will be reviewed to ensure appropriate documentation of behavior when prn anti-anxiety medication is administered. Residents receiving Valproic acid will be audited to ensure laboratory result is available as ordered. All residents receiving antipsychotic medications will be reviewed to ensure AIMS test were completed. C. Licensed staff and CNA's will be in-serviced by Staff Dev/Designee on behavior monitoring/documentation when resident is anxious and prn anti-anxiety medication is given. Licensed staff will be in-serviced to ensure laboratory result for Valproic acid is available as ordered. Licensed staff will be in-serviced by Staff	11/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/28/2017
NAME OF PROVIDER OR SUPPLIER: ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F329	Continued From page 22 (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for three (R107, R245, and R279) out of 5 sampled residents reviewed for unnecessary medications the facility failed to ensure the presence of adequate indication and/or monitoring of medications. R107 received Depakote for nearly one year without blood monitoring for toxic levels. R245 received 17 doses of Ativan without documented behaviors. R279 failed to have AIMS assessment initiated for the use of an antipsychotic. Findings include: 1. Review of R245's clinical record revealed: 2/13/17 - Returned to facility from a 3 week stay in a psychiatric hospital with multiple diagnoses including dementia and recurrent major depression with psychosis. Physicians' orders included PRN medications for restlessness, agitation, panic related to anxiety: - 3/14/17: Ativan 0.5 mg every 4 hours PRN - discontinued 9/1/17. - 9/1/17: Ativan 0.5 mg every 24 hours PRN - discontinued 9/9/17.	F329	Dev/Designee to ensure residents receiving antipsychotic medications have AIMS test completed initially then Q 6 months. D. Daily audit will be conducted by UM to ensure behavior is monitored/documented when a prn anti-anxiety medication is administered until 100% compliance x 7 days is achieved, followed by a weekly audit x 4, then monthly through the next quarter. Reports will be submitted to QA monthly. Weekly audits of residents with new orders for Valproic acid will be conducted x4 , followed by a monthly audit through the next quarter. Reports will be submitted to QA committee monthly. Weekly audit of new admission/new orders for anti-psychotic medications to ensure AIMS test was completed initially and every Q 6 months until a 100% compliance x7days is achieved, followed by a monthly audit through the next quarter. Reports will be submitted to QA committee monthly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

(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) COMPLETE DATE
F329	Continued From page 23 - 9/9/17: Ativan 0.25 mg once a day PRN restlessness, agitation, panic related to anxiety. June - September 2017 - Review of eMAR and nursing notes discovered that R245 received 22 PRN doses of Ativan for anxiety, two of which were given for restlessness after a fall. The other 20 had no behavioral assessments warranting the medication During an interview with E18 (UM) on 9/20/17 around 8:50 AM to review the lack of behavioral assessment prior to the administration of PRN Ativan in the nursing notes, E18 indicated the behaviors should be found in the behavior monitoring sheets (CNAs monitored for physical aggression and nurses for restlessness, fidgeting and physical aggression). Review of the behavior monitoring sheets found only three instances where behaviors were recorded during the shift the resident received the PRN medication for anxiety. 17 doses were administered without assessment of behaviors warranting the PRN medication: - Ativan 0.5 mg: June 17 and 27; July 1, 2, 3, 10, 15, 20 and 21; August 7, 14 and 18; and September 7 and 8 - Ativan 0.25 mg: September 9, 11 and 14. 2. Review of R107's clinical record revealed: 10/5/16 - Readmission after hospitalization at a psychiatric facility with multiple diagnoses. 10/5/16 - Physicians' orders included Depakote twice a day for psychosis. 3/7/17 - Psychology consult recommended to obtain the blood level of the Depakote (also known as valproic acid) every 6 months. R107's medical doctor initialed/dated the bottom of the	F329		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F329	Continued From page 24 consult on 3/8/17 acknowledging that the information was reviewed. 4/17/17 - Review of lab results discovered the resident's every 6 month lab tests were performed. There was no evidence that the valproic acid level was obtained with the other blood tests. 6/6/17 - Psychology consult recommended, again, to obtain the valproic acid level every 6 months. 6/6/17 - Physicians' orders included valproic acid level every 6 months on the 17th of the month, with the next due date being 10/17/17. During an interview with E6 (UM) on 9/19/17 at 9:25 AM E6 indicated the blood test was not available in the record, but talked to physician who ordered it every 6 months, starting 9/20/17. 3. Policy on antipsychotic medications last revised 9/2014 - Residents receiving psychoactive medications will be monitored for medications effectiveness, adverse reactions and side effects. Upon admission for new residents' already receiving antipsychotics and every 6 months thereafter, the facility will administer an AIMS (Abnormal Involuntary Movement Scale) test for the purpose of monitoring for tardive dyskinesia. The results will be recorded in the resident's medical record. The following was reviewed in R279's clinical record: 8/18/17 - Admission to facility.	F329		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F329	Continued From page 25 8/19/17 - Risperdal Tablet (Risperidone) 1 tablet by mouth one time a day related to Alcohol Dependence with Alcohol Induced Persisting Dementia 8/29/17 - Care Plan for use of antipsychotic medication with a goal that R279 would remain free of drug related complications including movement disorder. Interventions included: monitor/record/report to MD prn side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS. Review of the clinical record found no evidence that an AIMS was conducted on R279. During an Interview with E14 (UM) on 09/15/17 at 1:57 PM E14 confirmed there was not an AIMS completed or on file for R279. E14 did complete an AIMS for the record with a score of 0. These findings were reviewed with E1 (RDO), E2 (NHA) and E3 (DON) on 9/20/17 at 2:45 PM during exit conference.	F329		
F406 SS=D	483.65(a)(1)(2) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at 483.120(c), are required in the residentsl comprehensive plan of care, the facility must- (1) Provide the required services; or	F406	A. R32 was assessed by NP psychiatrist on 9/21/17. B. Active residents with Level II PASSR will be reviewed to ensure specific recommendations are carried out timely. C. Social Services will be in-serviced by Staff Dev/Designee regarding Level II PASSR review to ensure specific recommendations are carried out timely. D. Weekly audit of all new admissions with Level II PASSR will be conducted to ensure compliance with specific	11/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F406	Continued From page 26 (2) In accordance with 483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide specialized Level II services as recommended for one (R32) out 36 sampled residents. Findings include: Review of R32's clinical record revealed the following: 3/31/17 - PASRR Level II Determination of Mental Illness Recommendation documented that R32 required special services. The recommended servcies included that a psychiatrist was to review R32's mental health condition and assess for mental health needs on, at least, a monthly basis and supportive counseling was to be provided by a licensed mental health provider. 9/12/17 - A progress note written by E15 (NP) who was employed with the facility's contracted psychological services provider documented "attempted to see the patient but he is at dialysis I spoke to the E6 (UM) who informed me that patient is fairly stable with mood but is attention seeking and does seek pain med often. Will attempt to [sic] early in AM prior to dialysis next visit to facility." 9/14/17 - A progress note written by E15 documented "attempted to see patient, he is at	F406	Interventions in place until 100% compliance is achieved x 3, followed by a monthly through the next quarter. Reports will be submitted to QA committee monthly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F406	Continued From page 27 dialysis." During an interview on 9/19/17 at 2:29 PM with E6 it was confirmed that R32 has not seen a psychiatrist and that E15 was made aware of R32's dialysis schedule. During an interview on 9/19/17 at 3:06 PM with E10 (SW) it was confirmed that R32 had not received services from a psychiatrist and E10 reported that contact would be made to the facility's contracted company for psychiatric services for an appointment immediately that will also accommodate R32's dialysis schedule. According to the PASRR Level II Determination of Mental Illness, recommendations were for R32 to have special services that included a psychiatrist is to review R32's mental health condition and assess his mental health needs on at least a monthly basis and supportive counseling to be provided by a licensed mental health provider. The recommendations did not address the use of a NP in the place of the psychiatrist. R32 had not received any visits from a psychiatrist. These findings were reviewed with E1(RDO), E2 (NHA) and E3 (DON) on 9/20/17 at 2:45 PM during exit conference.	F406		
F441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying,	F441	A. E11 was educated regarding infection control procedure/proper handwashing after R6 wound dressing change. R126 is discharged from the facility. R295 is discharged from the facility. B. E11 will be observed during her next visit to ensure compliance with infection control/handwashing procedure after wound care.	11/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER: ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F441	Continued From page 28 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to 483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F441	Residents who were admitted in the last week will be audited to ensure PPD reading is within the 48-72 hours time frame. C. All staff including contracted staff will be in-serviced by Staff Dev./Designee on proper handwashing. Licensed staff will be in-serviced on appropriate timeframe to read PPD results. D. Daily staff observation will be conducted to ensure proper handwashing is practiced until 100% compliance is achieved x 7 days, followed by a weekly audit x 4, then monthly through next quarter. Reports will be submitted to QA committee monthly. Daily audit will be conducted on new admissions to ensure PPD is read within the established timeframe until 100% compliance is achieved x7 days, followed by a weekly audit x 4, then monthly through the next quarter. Reports will be submitted to QA committee monthly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/20/2017
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	

(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) COMPLETE DATE
F441	Continued From page 29 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facilitys IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility documents and interview it was determined that the facility failed to maintain an effective Infection Prevention and Control Program for three (R5, R126 and R295) out of 36 sampled residents. Handwashing was not conducted properly during R5's care. Step one PPD results were read outside of the 24-72 hour window for two (R126 and R295) out of 7 sampled residents. Findings include: 1. The facility policy on Handwashing/Hand hygiene last updated 4/2012 directs staff to "dry hands thoroughly with paper towels and then turn off the faucets with a clean, dry paper towel. During a dressing change observation on 9/19/17 at 10:02 AM for R5, E11 (NP) was observed washing her hands in the resident bathroom and then using her bare, wet hands to turn off the faucet four times:10:04 AM, 10:07	F441		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

PRINTED: 10/24/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	085037		09/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

(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) COMPLETE DATE
F441	Continued From page 30 AM, 10:08 AM and 10:10 AM. During an interview on 9/19/17 at 10:26 AM with E11 it was confirmed that proper handwashing technique was not followed during R5's wound care. 2 March 2017 MAR for R126 - PPD step one was administered on 3/28/17 at 8:25 PM and was read on 3/30/17 at 3:38 PM. 3. July 2017 MAR for R295 - PPD step one was administered on 7/4/17 at 4:42 AM and was read on 7/5/17 at 10:15 PM. During an interview on 9/20/17 at 2:45 PM, E3 (DON) explained that the MAR system being used records the time data is entered, therefore a staff member can administer the test at one time, then hours later document this on the system. The time recorded was the time the information was documented. These findings were reviewed with E1 (RDO), E2 (NHA) and E3 [DON] on 9/20/17 at 2:45 PM during exit conference.	F441		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Atlantic Shores Rehab and Health CTR. DATE SURVEY COMPLETED: September 20, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by references and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from September 12, 2017 through September 20, 2017. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was one hundred sixty three (163). The stage 2 survey sample was thirty six (36).	The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all applicable law. The facility has achieved substantial compliance with all requirements as of the completion date specified in the plan of correction for the noted deficiency. Therefore, the facility requests that this plan of correction serve as its allegation of substantial compliance with all requirements as of 11/19/17.	
3201	**Regulations for skilled and intermediate care facilities**		
3201.1	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed on September 20, 2017: F164, F272, F279, F282, F309, F314, F322, F329, F406, and F441	Cross refer to the plan of correction CMS 2567 survey completed on 9/20/17 for Federal Tags F164,F272,F279,F282,F309, F314,F322F329,F406,F441	

Provider's Signature Murray-Davis Title Administrator Date 10/24/2017

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care Residents Protection

3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Atlantic Shores Rehab and Health CTR. DATE SURVEY COMPLETED: September 20, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE

Provider's Signature _____ Title _____ Date _____