

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

PRINTED: 07/15/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085037</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>07/01/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ATLANTIC SHORES REHABILITATION &amp; HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced complaint survey was conducted at this facility from June 26, 2015 through July 1, 2015. The facility census the first day of the survey was 162. The survey sample was composed of eight records. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated.</p> <p>Abbreviations/Definitions used in this 2567 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;          MDS - Minimum Data Set (standardized assessment forms used in nursing homes);          CNA - Certified Nurse's Aide;          FSD - Food Service Director;          RD - Registered Dietitian;          NP-Nurse Practitioner;          ADLs - Activities of Daily Living, such as bathing and dressing;          cm - centimeter, unit of length;          kg - kilogram, measurement of mass;          mg - milligram, unit of mass;          mL - milliliter, unit of length;          PT - Physical Therapy;          I &amp; O - Intake and Output;          Intravenous (IV) - within the veins;          IV Fluids - fluids given in the vein;          Rehabilitation - treatment for recovery from injury</p>	F 000	<p>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 9/01/15.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE <b>Administrator</b>	(X6) DATE <b>7/23/15</b>
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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 000	Continued From page 1 or disease; Alzheimer's Disease - disorder of the brain that leads to loss of memory, thinking and language; Parkinson's Disease - disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement, and coordination; Dehydration-condition in which the body has less than normal fluid; Edema-excess water collecting in the body; Doppler ultrasound-device to measure the flow of blood through the blood vessels.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or	F 157	<p><b>A. Individual/Resident Impacted</b> The facility recognizes that there is no corrective action for R2 who was discharged on 1/11/15.</p> <p><b>B. Identification of other residents</b> An audit of the daily supervisors report and 24 hour progress notes in Point Click Care will be conducted by nursing administration to identify any situation that would prompt timely family/responsible party notification, in accordance with the facility policy. Any concern identified will be corrected immediately by immediate notification, if appropriate, and staff counseled as necessary.</p> <p><b>C. System Changes</b> On-going the nursing administration and/or the unit manager/designee will review the 24 hour Point Click Care nursing documentation daily to ensure compliance. This review will be in addition to reviewing the daily supervisors 24 hour report. Nursing staff will be in-serviced on "Change in Condition and Notification" by 8/17/15, and all new hires will be in-serviced at the time of hire. <b>See attachment A</b></p>	

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F 157	<p>Continued From page 2</p> <p>regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's policy and procedure and review of other facility documentation, it was determined that the facility failed to notify a responsible party of a change in condition for 1(R2)out of 8 sampled residents. Findings include:</p> <p>The facility's policy entitled Guidelines for Reporting a Change in a Resident's Condition or Status (revised 6/24/09) states: Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when there is a significant change in the resident's status.....Except in medical emergencies, notification to the family will be made within 24 hours of a change.....The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.</p> <p>On 1/2/15 R2 was admitted for rehabilitation after surgery for a broken hip. The resident was ordered a regular diet on admission.</p> <p>On 1/5/15 the physician ordered one liter of IV fluids for "clinical dehydration". There is no evidence of documentation in the medical record</p>	F 157	<p><b>D. Success Evaluation</b></p> <p>The ADON/designee will conduct daily audits of all residents with a change in condition from the daily supervisor's report for two weeks or until a 100% compliance is achieved. A weekly audit will be conducted for the next quarter. Audit results will be reported at the monthly and quarterly QAPI meetings.</p>	9/1/15
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F 157	Continued From page 3 that the resident's son was notified of this condition or new order.  Other facility documentation (memorandum entitled Education) dated 2/20/15 described education completed with E9 (Supervisor) and E10 (Unit Manager) regarding family notification about changes in resident condition and new orders.  The findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 7/1/15 at 1:00 PM.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged	F 225	<b>A. Individual/Resident Impacted</b> The facility recognizes that there is no corrective action for R2 who was discharged on 1/11/15  <b>B. Identification of other residents</b> Unit managers will review all weekly skin assessments to ensure that any changes in skin condition of unknown origin were reported, entered into the Point Click Care Risk Management and were investigated in a timely manner. All residents currently found at risk will be assessed immediately and weekly thereafter. Any concerns identified during this review will be reported to the DON / designee for prompt investigation.	

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F 225	<p>Continued From page 4</p> <p>violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of an investigative statement obtained by DLTCRP (Division of Long Term Care Resident's Protection) investigator, interview, record review, review of facility's policy and procedure and review of other facility documentation, it was determined that for one (R3) out of 8 sampled residents the facility failed to immediately report an injury of unknown source. Findings include:</p> <p>The facility's policy entitled, "Abuse of Residents" effective 7/13 states "Events, such as injuries of unknown origin, or suspicious injuries (i.e. bruising, skin tears) or allegations are investigated. These events are also evaluated in terms of occurrences in an attempt to identify cause and any potential patterns or trends. Patterns, once identified, are used to determine the direction of the investigation".</p> <p>The investigative statement, obtained by DLTCRP, dated 3/19/15 revealed on 3/17/15 AM, E19 (CNA) was assisting R3 to get into his</p>	F 225	<p><b>C. System Changes</b> Licensed professional nurses and nursing assistants will be educated on identification and timely reporting of any injury of unknown origin. All new hires will be in-serviced at the time of hire regarding abuse prohibition and timely notification of any injury of unknown origin when identified. Nursing supervisors will be in-serviced on initiating prompt investigation of all unknown injuries and report to the DON / designee in a timely manner by 8/17/15. <b>See Attachment B: Abuse of Residents Policy and Procedure: #4 &amp; #5.</b></p> <p><b>D. Success Evaluation</b> The unit manager/designee will conduct a daily audit of all residents due for a weekly skin assessment for two weeks or until three consecutive 100% compliance is met. Following will be a weekly audit of 10% of the total census in each unit until 100% compliance is achieved for three consecutive weeks. A monthly audit will be conducted and the results will be reported at the monthly and quarterly QAPI meetings.</p>	9/1/15

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F 225	<p>Continued From page 5</p> <p>wheelchair. E19 reports that she stood beside R3 like usual and R3 had some pain on his left side. R3 lifted his shirt and E19 stated that there was a large bruise on his left side (when asked by the investigator to show her how large the bruise was with her hands, E19 demonstrated an area approximately 4 inches by 3.5 inches). E19 told the investigator that the bruise was dark purple on the middle to lower part of his back. When asked by the investigator if E19 reported the bruise, E19 stated that she thought they knew about it because R3 told her it must have happened when he fell the other day (3/11/15).</p> <p>Interview with E5 (RN Unit Manager) on 6/29/15 at 12:30 PM revealed that CNAs are to inform the nurse of any change in resident's condition; in addition to documenting the change on the Stop &amp; Watch Report. E5 was not able to produce any documentation that the facility identified the bruise observed by E19 on 3/17/15.</p> <p>There was no evidence the facility identified this injury of unknown source resulting in the failure to immediately report and thoroughly investigate the bruise.</p> <p>These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 7/1/15 at 1:00 PM.</p> <p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 225		
F 281 SS=D		F 281	<p><b>Cross refer F325</b></p> <p><b>A. Individual/Resident Impacted</b></p> <p>The facility recognizes that there is no corrective action for R2 who was discharged on 1/11/15.</p>	

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F 281

Continued From page 6  
Cross Reference F325

Based on record review, it was determined that the facility failed to establish a temporary care plan for 1 (R2) out of 8 sampled residents. Findings include:

On 1/2/15 at 10:10 PM (Friday night) R2 was admitted to the facility for rehabilitation after surgical repair of a broken hip. Per written statement from the facility investigation dated 1/16/15, prior to resident arrival at the facility the admitting nurse (E11) received telephone report from the hospital nurse and discovered the resident had a poor appetite along with diagnoses of Alzheimer's Disease and Parkinson's Disease. E11 provided care to this resident over the next two days and learned from R2's son on 1/4/15 that the resident liked ham and cheese [sandwich] and loved coca cola.

1/6/15 at 3:13 PM E8 (NP) documented the resident received one liter of IV fluids. E8's documented plan included putting R2 on the hydration protocol and monitoring weights daily. E8 ordered that the resident be weighed daily for 1 week.

Intake records showed the resident ate the following amount of food served at breakfast, lunch and dinner during the first week at the facility:

1/3/15 - 50% of dinner  
1/4/15 - 25% of lunch and dinner  
1/5/15 - 50% of breakfast and dinner  
1/6/15 - 25% of breakfast and lunch; 50% of dinner  
1/7/15 - 25% of lunch; 50% of dinner  
1/8/15 - 25% of dinner

F 281

**B. Identification of other residents**  
All residents newly admitted/readmitted will be assessed to ensure that a nutritional care plan is in place as necessary, in accordance with the resident's needs.

**C. System Changes**  
The dietician will ensure that within seven days of admission a Nutritional Care Plan is in place. A Nutritional Care Plan template will be created by dietician to be used by nursing on admission for residents with special dietary needs. All nursing staff will be educated on the temporary Nutritional Care Plan by 8/17/15, and all new hires will be in-serviced at the time of hire.  
See attachments A and C

**D. Success Evaluation**  
A weekly audit of newly admitted residents who are identified at risk for nutritional status imbalance will be conducted to ensure that an appropriate care plan is in place within seven days of admission until 100% compliance is achieved for three consecutive weeks. Following will be a monthly audit of 10% sample of newly admitted residents for the next quarter. Concerns identified will be reported to the DON/designee who will ensure compliance. Audit results will be reported at the monthly and quarterly QAPI meetings.

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F 281	Continued From page 7 1/9/15 - 75% of lunch; 25% of dinner  Despite written orders from the NP dated 1/6/15 and before the nutritional assessment by E16 (RD) on 1/10/15 the facility failed to develop a temporary care plan for R2 addressing R2's poor intake, weight, hydration and identified food preferences.	F 281		
F 325 SS=D	These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 7/1/15 at 1:00 PM. 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of documentation from the DLTCRP (Division of Long Term Care Residents Protection) investigator, it was determined that the facility failed to monitor and maintain the nutritional status for 1 (R2) out of 8 sampled residents by not weighing the resident daily according to a physician order and failed to perform a timely	F 325	<b>Cross refer F281</b> <b>A. Individual/Resident Impacted</b> The facility recognizes that there is no corrective action for R2 who was discharged on 1/11/15.  <b>B. Identification of other residents</b> All current residents with orders for daily weights will be identified. An audit will be conducted to ensure that weights are being completed as ordered and documented.  <b>C. System Changes</b> All residents with orders for daily weights will be documented on the TAR and into Point Click Care. The unit manager will oversee this process to ensure compliance. Nursing staff will be in-serviced on the daily weight process and appropriate documentation by 8/17/15, and all new hires will be in-serviced at the time of hire. <b>See attachment A</b>	

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F 325	<p>Continued From page 8 nutritional assessment. Findings include:</p> <p>Facility policy entitled Weight Assessment and Intervention (revision date April, 2007) stated that "nursing staff will measure resident weights on admission".</p> <p>R2 was admitted to the facility on 1/2/15 for rehabilitation after surgery for a broken hip. The resident had Alzheimer's disease and Parkinson's disease.</p> <p>The Nursing Communication Record from the hospital dated 1/2/15 listed R2's weight as 70.2 kg [equals 154.4 pounds] and height as 177.8 cm (equals 70 inches or 5 foot 10 inches).</p> <p>On 1/2/15 (Friday) at 10:35 PM E11 (LPN) documented R2 arrived at facility at 10:10 PM. The nurse recorded the resident's height as 70 inches tall, weight as 154.4 pounds and the scale type as the lift scale. The documented weight was the exact same number as what was on the hospital's transfer form.</p> <p>The Physician order from 1/2/15 included weekly weight for 4 weeks.</p> <p>On 1/3/15 (Saturday) the intake record showed the resident ate nothing for breakfast or lunch, and ate 50% of dinner. At 8:56 PM E11 documented intake poor, less than 25%, and that she encouraged fluids by mouth.</p> <p>On 1/4/15 (Sunday) the intake record showed R2 ate nothing for breakfast, 25% of lunch and 25% of dinner. At 8:52 PM E11 documented intake poor, less than 50%, and that she encouraged fluids by mouth.</p>	F 325	<p><b>D. Success Evaluation</b> A weekly audit of all residents with ordered daily weights will be conducted to ensure that daily weights are obtained until 100% compliance is achieved for three consecutive weeks. Following will be a monthly audit of all residents on daily weights for the next quarter. Any concerns will be reported to the DON/designee who will ensure compliance. Audit results will be reported to monthly and quarterly QAPI meetings.</p>	9/1/15
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NAME OF PROVIDER OR SUPPLIER  <b>ATLANTIC SHORES REHABILITATION &amp; HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966</b>
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(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 325	<p>Continued From page 9</p> <p>On 1/5/15 (Monday) E13 (Physician) ordered one liter of IV fluids to be infused over 10 hours for "clinical dehydration". The intake record from 1/5/15 showed R2 ate 50% of breakfast and lunch, but ate no dinner.</p> <p>On 1/6/15 (Tuesday) at 3:08 AM E14 (LPN) documented that R2 "refused care all shift" including assistance with oral intake.</p> <p>On 1/6/15 at 3:13 PM E8 (N P) documented the resident received one liter of IV fluids. E8's documented plan included putting R2 on hydration protocol and monitoring weights daily. E8 ordered blood tests and for the resident to be weighed daily for 1 week.</p> <p>The intake record from 1/6/15 showed that R2 ate 25% of breakfast, 25% of lunch and 50% of dinner.</p> <p>The evaluation on 1/7/15 (Wednesday) by Speech and Language Therapy recommended R2 to be "fed all meals by staff" and for the resident to "be out of bed to wheelchair for lunch and dinner meals".</p> <p>On 1/7/15 the intake record showed the resident had nothing for breakfast, ate 25% of lunch and 75% of dinner.</p> <p>1/8/15 (Thursday) at 12:13 PM E14 (LPN) wrote the resident "refused to let staff assist with meals. Snacks provided within reach." The nurse documented that R2 drank 120 mL (4 ounces) of nutritional supplement and 120 mL (4 ounces) of orange juice. E14 wrote the resident had "poor intake with lunch, accepts 120 mL (4 ounces)</p>	F 325		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	<p>Continued From page 10</p> <p>water." The intake record from 1/8/15 showed the resident ate nothing for breakfast or lunch and ate 25% of dinner.</p> <p>The Medicare 5-day MDS Assessment on 1/9/15 by E15 documented the resident required extensive assistance by one staff member for eating and had difficulty chewing due to missing/broken teeth and never having dentures.</p> <p>On 1/9/15 (Friday) the intake record showed the resident ate nothing for breakfast, 75% of lunch and 25% of dinner.</p> <p>The treatment record with daily weights at 6:00 AM in January, 2015 had "ref" [refused] handwritten for January 7, 8, 9, and 10th. The area for January 11 was blank.</p> <p>On 1/10/15 (Saturday), 8 days after admission, E16 (RD) documented a nutritional assessment and determined diet needs using the admission height and weight as no other weight was recorded. The dietitian wrote that R2 ate less than 25% of his regular diet and received feeding assistance. The resident was very agitated and he pushed his breakfast tray on the floor but did eat a sandwich that was offered after the tray was spilled. E16 documented the plan to start the hydration protocol and to add 2 cal (high calorie diet supplement) 120 mL to be given three times a day after meals.</p> <p>On 1/11/15 (Sunday) at 1:06 PM E17 (LPN) documented the resident was sent to the hospital for evaluation and treatment of neck swelling.</p> <p>The facility investigation included a written statement dated 1/16/15 by E11 documented that</p>	F 325		

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F 325	<p>Continued From page 11</p> <p>conversation with the nurse at the hospital on the day of admission included that the resident had poor appetite. E11 took care of this resident the entire weekend following the Friday night admission to the facility. E11 spoke with R2's son on the Sunday after admission and found out the resident liked "simple ham and cheese and loved coca cola". The nurse wrote that "unit assistants spent time, multiple attempts to encourage oral intake, introduce different fluids" during his stay.</p> <p>Review of the closed medical record revealed no temporary care plan. A care plan addressing R2's poor intake or food preferences (identified two days after admission) was not developed.</p> <p>Interview with E2 (DON) and E5 (Unit Manager) on 7/1/15 at 10:20 AM confirmed the lift scale used by the facility was a sling-type. This type of scale requires the resident to be rolled from side to side for a sling to be placed under the resident. The resident is then lifted off the bed surface and a weight taken. E5 stated it is the expectation that a full set of vital signs (blood pressure, temperature, heart rate, respiration rate) and weight be obtained on admission. E2 described an alternate way for obtaining weights, besides the lift scale, would be to use a wheelchair scale. Between 10:30 AM and 10:50 AM E8 (Unit Manager where R2 resided) verified the only weight recorded in the medical record was the one on admission. E8 did not locate additional weights in the weight binder on the unit and provided no information as to why the weights were not obtained and if the use of the wheelchair scale had been attempted.</p> <p>R2 had documented poor intake and received a liter of IV fluids within three days of admission.</p>	F 325		

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F 325	Continued From page 12  The admission weight was exactly the same as the weight documented on the transfer form from the hospital. Daily weights were ordered but not obtained at 6:00 AM nor was the resident weighed later in the day when he was in a wheelchair. The nutrition assessment was conducted more than one week after admission for this resident. The facility failed to obtain and monitor R2's nutritional status and weight in the presence of poor meal intake, an NP order for monitoring weights and a physician documented diagnosis of dehydration.  The findings were reviewed with E1 (NHA), E2 and E3 (ADON) on 7/1/15 at 1:00 PM.	F 325		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on record review; interview and review of other facility documentation, it was determined that the facility failed to have accurate and	F 514	<b>A. Individual/Resident Impacted</b> The facility recognizes that there is no corrective action for R7 who expired on 5/23/15.  <b>(#1a)</b> <b>B. Identification of other residents</b> All residents' records will be reviewed to ensure skin assessments are completed as ordered. Any concerns identified will be immediately addressed and reported to the DON/designee who will ensure compliance.  <b>C. System changes</b> All licensed nursing staff will be in-serviced on the completion of the Weekly Skin Assessment per physician's orders by 8/17/15, and all new hires will be in-serviced at the time of hire. <b>See attachment A</b>	



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F 514	<p>Continued From page 14</p> <p>On 12/16/14 the progress note written by E7 (LPN) at 6:25 PM recorded "doppler to right leg for swelling".</p> <p>On 12/17/14 at 12:13 PM E5 (Unit Manager) wrote "Per mobile report Doppler results appear negative for DVT of LLE".</p> <p>Progress note on 12/17/14 at 12:29 PM by E6 (RN) recorded edema of "LLE".</p> <p>On 12/18/14 at 4:16 PM E18 (LPN) documented edema of "LLE".</p> <p>Progress note by E8 (Nurse Practitioner) on 12/18/14 at 5:18 PM recorded that R7 had an ultrasound done of the "right lower extremity, which was negative for DVT".</p> <p>On 12/19/14 at 1:56 PM E18 described LLE edema.</p> <p>On 1/8/15 at 11:31 AM E6 documented LLE edema.</p> <p>On 2/3/15 at 2:21 PM E4 (Physician) described LLE edema and stated there was no edema in RLE (right lower extremity/leg).</p> <p>The medical record was not accurate in describing which of R7's leg had edema for 2 of the 9 documented entries describing the edema.</p> <p>The findings were reviewed with E1 (NHA), E2 (DON) and E3 on 7/1/15 at 1:00 PM.</p>	F 514		
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**DELAWARE HEALTH  
AND SOCIAL SERVICES**

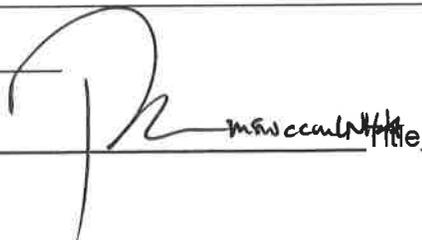
Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-6661

**STATE SURVEY REPORT**

**NAME OF FACILITY:** Atlantic Shores Health and Rehabilitation Center      **DATE SURVEY COMPLETED:** July 1, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p><b>3201</b></p> <p><b>3201.1.0</b></p> <p><b>3201.1.2</b></p>	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced complaint survey was conducted at this facility from June 26, 2015 through July 1, 2015. The facility census the first day of the survey was 162. The survey sample was composed of eight records. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>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.</b></p> <p><b>This requirement is not met as evidenced by:</b> Cross Refer to the entire CMS 2567-L survey completed July 1, 2015 F157, F225, F281, F325, and F514.</p>	<p>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 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 9/01/15.</p> <p>Cross refer to plan of correction CMS 2567-L survey completed 7/1/15 for Federal Tags F157, F225, F281, F325, and F514.</p>	

Provider's Signature  Title Administrator Date 7/23/15