DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Atlantic Shores

DATE SURVEY COMPLETED: June 10, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced Complaint Survey was conducted at this facility from June 6, 2024 through June 10, 2024. The deficiencies contained in this report are based on interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 162. The survey sample size was 24.	
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**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 June 10, 2024: cross refer: F689 and F755.	

Provider's Signature Brenda Dexter Title NHA Date 6/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085037	A. BUILDING _____ B. WING _____	C 06/10/2024

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

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F 000	INITIAL COMMENTS An unannounced Complaint Survey was conducted at this facility from June 6, 2024 through June 10, 2024. The deficiencies contained in this report are based on interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 162. The survey sample size was 24. CNA - Certified Nurse Assistant; DON - Director of Nursing; IDT - Interdisciplinary Team; IP - Infection Preventionist; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; QA - Quality Assurance; RN - Registered Nurse; UM - Unit Manager; Aemia - low level of hemoglobin, the red blood cell chemical that carries oxygen to body tissues or a condition in which you don't have enough healthy red blood cells to carry adequate oxygen to your tissues which may make you feel tired and weak; Brief Interview for Mental Status (BIMS) - test to measure thinking ability with score ranges from 0 to 15. 13-15: Cognitively intact 8-12: Moderately impaired 0-7: Severe impairment; ED - Emergency Department; Epithelial - relating to the thin tissue forming the outer layer of the body's surface; ER - Emergency Room; Eschar - dead tissue that is tan, brown or black	F 000		

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

Electronically Signed | 07/01/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 and tissue damage more severe than slough in the wound bed OR dead tissue forming a hard scab; usually black in color; Hemiparesis - the unilateral weakness of the entire left or right side of the body; Hemiplegia - half of body paralyzed; Laceration - cut/tear in skin; Minimum Data Set (MDS) - a standardized set of assessments completed in nursing homes; Narcotic- a drug or other substance that affects mood or behavior; RCA - root cause analysis; Reconciliation - the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. Scalp - head; Xeroform- a medical dressing that has antiseptic and antibacterial properties used to cover wounds made of fine mesh gauze.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined that for one (R15) out of four residents reviewed for accident hazards,	F 689	R15 returned from the hospital and received treatment for the scalp laceration.	7/16/24

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F 689	Continued From page 2 the facility failed to ensure the resident's environment was free of accident hazards. On 6/3/24, while being transported in the facility van, R15 fell from the wheelchair due to improper restraining. R15 was taken to the hospital for treatment of a cut to the forehead. The unsafe facility transport caused R15 harm. Findings include: An undated facility instruction guide titled "Driver/Operator Instruction Guide QRT MAX" included: Step 2. Attach lap and shoulder belt. Belt should bear upon the bony structure of the body and should be worn low across the front of the pelvis with the junction between the lap and shoulder belts located near the passenger's hip. Adjust the bets as firmly as possible consistent with user comfort. A review of R15's clinical record revealed: 11/30/18 - R15 admitted to facility with diagnoses including but not limited to, hemiplegia and hemiparesis affecting the left side. 4/29/24 - A quarterly MDS documented R15 had a documented BIMS score of 13, revealing an intact cognitive state. R15 was documented as requiring moderate assistance to change from sitting to standing position and to transfer from a bed to a wheelchair. 6/3/24 4:57 PM - A hospital history and physical report by P1 (MD) documented that "[R15] is a 56-year-old male who is wheelchair-bound ... Apparently [R15] was traveling in the van and as per records seems like he was unrestrained in his wheelchair in the van. Apparently upon taking a sharp turn [R15] fell out of his wheelchair and in	F 689	Wheelchair-bound residents who are transported in the Center's vehicles are potentially affected. Residents transported in the last 14 days were reviewed. No other incidents related to transport were identified. E13 was suspended from the Driver position immediately after the incident and was subsequently re-assigned to a different position. E13 was re-educated including return demonstration regarding steps to appropriately secure residents during transport. Root cause analysis is lack of proper securement of shoulder strap to wheelchair during van transport. through education including return demonstration/competency. Current drivers were re-educated, including return demonstration, on steps regarding how to appropriately secure a resident during transport. Regional Director of Maintenance/designee will conduct observational audits of van drivers for securement for transport weekly for four weeks or until 100% compliance is achieved. Audits will then be conducted monthly for three months to ensure sustained compliance. Audit findings will be reported to QAPI Committee.	

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F 689	Continued From page 3 the process bumped his forehead. [R15] was brought to the emergency room as a trauma code. There is a small laceration on the forehead ...". "Status post fall from the wheelchair: Patient has been evaluated by trauma. CT of head, neck, chest abdomen pelvis without any acute findings of trauma. Patient does have a minor scalp laceration and has been evaluated by surgery." 6/4/23 1:25 PM - A nurses note by E9 (Nurse Unit manager) documented that R15 was "Admitted to Beebe with symptomatic anemia and a scalp laceration [status post] fall ... ". 6/5/24 12:38 PM - A provider note by E11 (CRNP, APRN-C) documented that " ... [R15] seen after returning from hospital. He is returning here from an appointment with a specialist, fell out of his wheelchair and sustained a laceration to his forehead. He was taken to the ED. Imaging was negative for any acute injury ...". 6/5/24 - A wound assessment report by E12 (Wound NP) documented that R15 had a 3.5 cm x 3.5 cm x 0.2 cm laceration to the scalp with the appearance of 75-99% epithelial cells and 1-24% eschar. The treatment was to cleanse with normal saline and apply xeroform or a bordered gauze every day or as needed. 6/6/24 2:39 PM - An observation of R15 revealed a wound dressing to the left forehead and a standard sized wheelchair in the room next to the bed. In an interview with R15, he was unable to recall any specific details of the incident on 6/3/24. 6/6/24 2:58 PM - An interview with E13 (Van Driver) revealed that she was driving R15 to an	F 689		

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F 689	Continued From page 4 appointment on 6/3/24 and she secured the hooks to the wheelchair frame and secured the lap belt to the floor anchor then through the wheelchair's armrests and anchored to the floor on the opposite side appropriately. E13 stated that along the way she drove around a roundabout and looked up in the rearview mirror at R15 who had his eyes closed, calm and was slightly hunched over. E13 had driven around a second roundabout and heard a "bang." E13 looked over her shoulder and saw R15's whole body on the floor with the lap belt on him. E13 stated that she saw blood on the floor and a cut on R15's head and didn't touch or move R15. E13 stated during her initial training, the maintenance director showed her the lap belt but could not remember being shown the shoulder belt. E13 stated that "the shoulder belt doesn't really do anything." 6/6/24 3:20 PM - An observation made with E13 in the same transport van used during the incident when E13 demonstrated where the wheelchair was placed and the position of R15 after the fall. E13 stated R15 was between the right side of the wheelchair and the right sliding passenger door of the van. R15's head was towards the back of the van and his feet were towards the front. E13 stated that R15 must have hit his head on one of the floor anchors. 6/10/24 10:33 AM - An interview with P2 (EMT) revealed that R15 was laying on the floor of the transport van between the wheelchair and the right sliding passenger door of the van. R15's head was towards the back of the van and feet were towards the front of the van. R15 was in a fetal position with an injury to the head that was bleeding. P2 stated that there was no lap belt of	F 689		

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F 689	Continued From page 5 any kind on the resident when they arrived and they did not have to unbuckle any belts to remove the resident onto a stretcher. The facility failed to safely restrain R15 in the transport van which resulted in R15 falling out of the wheelchair where he hit his head and was transported to the hospital. 6/10/24 2:40 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA and IP) and E4 (Regional Consultant) during the exit conference.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		7/16/24

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F 755	Continued From page 6 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that in accordance with accepted professional standards and practices, the facility failed to maintain the Controlled Drug Count Record report accurately and completely for the month of May 2024. The facility did not accurately reconcile the transfer of controlled drugs from one shift to another. Findings include: Review of the Controlled Drug Count Record report for the month of May 2024 revealed the following: 5/2/24 - 3:00 PM - 11:00 PM shift lacked evidence that the narcotic count was completed for "Nurse Reporting On" and there was no entry for "Received From Pharmacy (+)." 5/3/24 - 11:00 PM - 7:00 AM shift lacked evidence that the narcotic count was completed for "Nurse Reporting On." 5/7/24 - Under the 3:00 PM - 7:00 AM shift, the "Received from Pharmacy (+)" number was scribbled out and it appears that it was initially marked as "0" and then changed to "1". 5/8/24 - Under the 11:00 PM - 7:00 AM shift the	F 755	No resident was impacted. No residents were identified with the potential to be affected. Root cause analysis determined that Licenses Nurses lacked following the narcotic count procedure related to documentation during change of shift. The procedure for shift-to-shift narcotic count transfer of controlled drugs was revised. Licensed nurses were educated by Staff Development/Designees regarding the procedure revisions. Unannounced audits of change of shift controlled drug counts will be conducted by the Shift Supervisors on each nursing unit weekly for four weeks or until 100% compliance is achieved, then monthly for three months. Results will be reported to the QAPI Committee, which will determine the need for further audits.	

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F 755	Continued From page 7 following categories were not completed: "Completed/Disposed (-)", "Received from Pharmacy (+)" and "# Items in Drawer". 5/9/24 - Under the 11:00 PM - 7:00 AM shift, the following categories were not completed: "Nurse Reporting ON (11-7)", "Completed/Disposed (-)", "Received from Pharmacy (+)" and "# Items in Drawer". 5/10/24 - No one signed under "Nurse Reporting OFF (11-7)" or recorded the number of items in the drawer. Additionally, under the 3:00 PM - 11:00 PM shift, someone marked over "0" with a "1," making the entry difficult to decipher. Under 11:00 PM - 7:00 AM shift the following categories were not completed: "Completed/Disposed (-)", "Received from Pharmacy (+)" and "# Items in Drawer". 5/11/24 - Under the 7:00 AM - 3:00 PM shift, at the beginning of the shift, there were 21 items with nothing received or disposed of, yet it appears that the number of items in the drawer is "20." Under the 3:00 PM - 11:00 PM shift, the number of items in the drawer was written over, making the number difficult to decipher. 5/13/24 - Under the 11:00 PM - 7:00 AM shift, it appears that the number 2 was entered and then written over with a "0," making the entry difficult to decipher. 5/15/24 - Under the 3:00 AM - 11:00 PM shift, the following categories were not completed: "Nurse Reporting On 3-11", "# Items in Drawer" (both oncoming and off going), "Completed/Disposed (-)", and "Received from Pharmacy (+)".	F 755		

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F 755	Continued From page 8 6/7/24 1:35 PM - In an interview, E1 (NHA) and E2 (DON) confirmed that the facility did not accurately reconcile the transfer of controlled drugs from one shift to another. 6/10/24 2:40 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA and IP) and E4 (Regional Consultant).	F 755		