



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Health Care Quality

Office of Long-Term Care
Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Harbor Healthcare & Rehabilitation Center **DATE SURVEY COMPLETED:** October 10, 2022

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced Complaint Survey was conducted at this facility from October 3, 2022 through October 10, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was one- hundred and eleven (111). The survey sample totaled twenty-one (21) residents.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Scope</p> <p>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.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross Refer to the CMS 2567-L survey completed October 10, 2022: F812.</p>		

Provider's Signature

Title

NHA

Date

10/14/2022



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

PRINTED: 11/09/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/10/2022
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS An unannounced Complaint Survey was conducted at this facility from October 3, 2022 through October 10, 2022. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 111. The survey sample totaled 21 residents. Abbreviations/definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; FSD - Food Service Director.	F 000			
F 812 SS=F	Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		11/24/22	

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

TITLE

(X6) DATE

Electronically Signed

10/14/2022

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 812	<p>Continued From page 1 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on review of the food temperature logs and staff interview, it was determined that the facility failed to consistently monitor food temperatures prior to food service. Findings include:</p> <p>10/10/22 9:35 AM - A review of facility food temperature logs between between April 1, 2022 and September 30, 2022 revealed that 75 out of 549 (13.7%) meals served lacked evidence that food temperatures were monitored.</p> <p>10/10/22 10:10 AM - During an interview, E3 (FSD) confirmed that temperatures were not taken at every meal.</p> <p>Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 10/10/22, beginning at approximately 2:15 PM.</p>	F 812	<ol style="list-style-type: none"> 1. Once informed by surveyor the VPO in-serviced Food Service Director (FSD) on the need to follow policy and take food temperatures for every meal. 2. Has the potential to affect all residents 3. <ol style="list-style-type: none"> a. RCA was determined that the food service department was not following the facility's policy regarding food temperatures b. FSD will in-service all food service employees on the need to follow the facility policy regarding taking temperatures daily. c. C. FSD/designee will audit temperature logs daily and will report out compliance daily in morning meeting. 4. Results of audits will be reported out in monthly QA until 100% compliance is achieved for 3 months. 	
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