

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

Page 1 of 1

NAME OF FACILITY: Atlantic Shores

DATE SURVEY COMPLETED: April 25, 2024

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201 3201.1.0 3201.1.2	An unannounced complaint survey was conducted at this facility on April 25, 2024. The facility census the first day of the survey was 166. The survey sample totaled three (3) residents. The survey process included observations, interviews, review of residents' clinical records and other documentation, as indicated. Regulations for Skilled and Intermediate Care Nursing Facilities Scope 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. No deficiencies were identified at the time of the survey.	

Provider's Signature _	Soule,	Deckler	Title	NHA	Date 5/1	120 54

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		085037	B. WING			C 04/25/2024	
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966	DDE		20.2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	(X5) COMPLETION DATE	
F 000	conducted at this fa facility census the fi The survey sample The survey process interviews, review o and other documen No deficiencies were	omplaint survey was acility on April 25, 2024. The irst day of the survey was 166. totaled three (3) residents. Included observations, of residents' clinical records	F 0	TITLE			X6) DATE
Electronically Signed							

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.

05/01/2024