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 10/14/2020

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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced complaint survey was conducted at this facility from October 13, 2020 through October 14, 2020. 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 one hundred forty-three (143). The survey sample totaled ten (10) plus three (3) additional subsampled residents.

Abbreviations/Definitions used in this report are as follows:

NHA - Nursing Home Administrator;
DON - Director of Nursing;
ADON - Assistant Director of Nursing;
RN - Registered Nurse;
LPN - Licensed Practical Nurse;
MD - Medical Doctor;
NP - Nurse Practitioner;
CNA - Certified Nurse's Aide;
UM - Unit Manager;

Intravenous (IV) - existing or taking place within, or administered into, a vein;
Lumen - the cavity or channel within a tube or tubular organ, as a blood vessel;
MAR (Medication Administration Record) - list of daily medications to be administered;
PICC - An inserted catheter is a form of intravenous access that can be used for a prolonged period of time or for administration of substances, such as medication;
SBAR (Situation, Background, Assessment, Recommendation) - tool to communicate with other members of the health care team;

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/14/2020

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F 000	Continued From page 1 Severe Cognitive Impairment - unable to make own decisions.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge,	F 623		12/11/20

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F 623	Continued From page 2	F 623		

under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder

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F 623	Continued From page 3 established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R1) out of four transfer notices reviewed the facility failed to ensure the complete written notification provided to the resident representative included the reason for the transfer. Findings include: Cross Refer F842 Review of R1's clinical record revealed: 3/14/2020 - R1 was sent to the hospital for a change of medical condition. The written notification to the responsible party failed to include the reason for the transfer. 10/14/2020 at 12:25 PM) - During an interview,	F 623	The filing of this plan of correction does notconstitute any admission as to any of theviolations set forth in the statement ofdeficiencies. This plan of correction isbeing filed as evidence of the facility'scontinued compliance with all therequirements as of the completion datespecified in the plan of correction for thenoted deficiency. Therefore, the facilityrequests that this plan of correction serveas it's allegation of substantial compliance with all the requirements as of 12/11/2020. A. Resident #1 is no longer in the facility. No further correction needed.	

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F 623	Continued From page 4 E2 (DON) confirmed the missing information. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (QA) on 10/14/2020 during the exit conference beginning around 3:00 PM.	F 623	B. An audit will be conducted by the Unit Managers or designee of all residents discharged to an acute care setting within the last 30 days to ensure the notice of discharge to the resident and representative included the reason for discharge. In an event where the reason for discharge is missing, the facility will send corrected notice. C. A root cause analysis was conducted and it was determined that the missing information was related to the staff assigned to send out written notices was not using a system to obtain transfer information for a resident. 1. During an acute care transfer, the supervisor/second nurse will verify that the notice of discharge included the reason for transfer. The Nursing supervisor will then be required to immediately update the facility□'s electronic transfer log-Hospital Tracking section of the facility□'s health record system. The facility□s Hospital Transfer log will be reviewed for completeness and accuracy, by the clinical leadership team each morning in the clinical meeting. 2. Assigned staff Front Desk Receptionist/Designee will refer to the electronic transfer log-Hospital Tracking section located in the facility□s electronic health records to determine the reason for a resident□s transfer. This information will be included in the written notice that will be mailed to the resident representative. In the event the reason indicated for	

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F 623	Continued From page 5	F 623	transfer is other the assigned staff will clarify reason for the resident□s transfer with the Director of Nursing or designee. 3. Staff Development/Designee will in-service all Licensed Nurses as well as staff assigned to mail out written transfer notices on the above process. D. The DON or Designee will conduct daily audit of all transfers to acute care facility x 1 week until a 100 % compliance is achieved. Following will be a weekly audits x 4 weeks of all acute care transfers. Audits will continue monthly x 2 of 5 residents, until 100% compliance is achieved and sustained. In an event where continued non-compliance is observed, facility will review and revise plan of correction to sustain compliance. Findings will be reviewed in the QAPI meetings monthly x 3 months.	
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation as indicated, it was determined that for one (R7) out of four sampled residents reviewed for neglect, the facility failed to maintain R7's PICC line (a peripherally inserted	F 694	A. Resident #7 is no longer in the facility. No further correction needed. B. An audit will be conducted by the Unit Managers or designee of all current	12/11/20

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F 694	Continued From page 6 central catheter, a form of IV access) as ordered by the physician. Findings include: Review of R7's clinical record revealed: A facility policy entitled "[name of pharmacy company] Infusion Intravenous (IV) Access Line Maintenance Protocol" last revised December 1, 2018 included that flush protocols were different for each type of PICC lines: -Flush Protocols. Intermittent non-valved PICC line: Flush with NS (normal saline), [administer] medication, [flush with] a blood thinner to prevent blood clots. - Intermittent valved PICC line: flush with NS [administer] medication, [and then flush with] NS. 3/26/2020 - R7 was admitted to the facility after having surgery to the right ankle related to an infection which required IV antibiotic therapy. 3/26/2020 - R7's hospital interagency (transfer form) sent to the nursing home on admission documented that R7 had a single lumen [non-valved] PICC line. 3/26/2020 - A physician's order for R7 included an antibiotic to be given through the PICC line once a day. 3/26/2020 - A physician's order in R7's medication administration record included the following: -[name of blood thinner] flush PICC non-valved [with] 5 ml every shift. Flush with Normal Saline, infuse medication, then Normal Saline, follow with	F 694	residents with PICC line to ensure appropriate flush orders are in place, and that flushes are documented appropriately. In an event the audit reveals non-compliance, facility will immediately correct these findings. C. A root cause analysis was conducted on new admission orders and it was determined that an additional flush order was inserted into the resident□s medical record by an auditor who did not complete the required chart audit for accuracy and appropriateness of a new admission's flush orders. 1a. Upon the admission of a resident, the nursing supervisor and the admitting nurse, will complete a head to toe assessment of the resident to determine whether the resident has Intravenous (IV) access. If the resident is noted with IV access, a dressing change will be initiated by the supervisor to ensure that an initial assessment is accurately documented of the IV site, length of catheter and arm circumference (if applicable). The appropriate care maintenance orders such as flush orders, dressing changes etc. will then be initiated per the facility protocol. 1b. During the clinical morning meeting on weekdays (within 72 hours in the case of the weekend, admission orders will be reviewed by the nursing leadership team to observe for medication administration orders requiring intravenous access, and to ensure that the correct flush orders are	

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F 694	Continued From page 7 5 ml of blood thinner. -Normal Saline flush PICC valved. Flush with Normal Saline, infuse medication, then Normal Saline. The non-valved PICC line should be flushed with both Normal Saline and a blood thinner, while a valved PICC line required only Normal Saline. March 2020 - Review of the MAR revealed that the nursing staff were documenting the administration of the valved and the non-valved orders daily every shift (from 3/26/2020 through 3/30/2020) except for the evening shift on 3/28/2020, when neither of the flushes were administered. 10/14/2020 10:33 AM- During an interview, E2 (DON) confirmed that the medical record lacked evidence of R7 receiving a PICC line flush on the evening of 3/28/2020. E2 confirmed that the two different PICC line flush orders were confusing and that R7 had a non-valved PICC line. E2 stated that R7 was only being administered the IV antibiotic once a day and should only receive a Normal Saline and [blood thinner] PICC flush after the daily antibiotic therapy. On the other two shifts, R7 was only to have the PICC line flushed with Normal Saline. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (QA) on 10/14/2020 during the exit conference beginning around 3 PM.	F 694	in place. 1c. An in depth chart review will be conducted by the Unit Manager or designee the following day (within 72 hours in the case of the weekend); this second review will ensure that all flush orders are appropriate for the IV access the resident has in place. 1d. The Staff Development/Designee will in-service the front line nurses, nursing Supervisors and Management on the above process. Education will include but not limited to, obtaining the appropriate flush orders as per the facility□s policy, accurate flush documentation, as well as the process for completing a thorough and comprehensive new admission chart audit using the medical record new admission chart audit as a point of reference. D. The DON or Designee will conduct daily audit of all residents with PICC lines to ensure appropriate flush orders are in place and appropriate documentation are completed x 1 week until a 100 % compliance is achieved. Following will be a weekly audit x 4 weeks of all residents with PICC lines. Audits will continue monthly x 2 of all residents with PICC lines, until 100% compliance is achieved and sustained. In an event where continued non-compliance is observed, facility will review and revise plan of correction to sustain compliance. Findings will be reviewed in the QAPI meetings	

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F 694	Continued From page 8	F 694	monthly x 3 months.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		12/11/20

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's 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;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation

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F 842	Continued From page 9 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. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to accurately document a change of condition for one (R1) out of four residents sampled for neglect. Findings include: Review of R1's clinical record revealed:	F 842	A. Resident #1 is no longer in the facility. No further correction needed. B. An audit will be conducted by the nursing management staff/or designee of all residents transferred to an acute care setting within the last 30 days. Audit will focus on documentation of the	

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F 842	Continued From page 10 2/17/2020 - Admission to the facility for rehabilitation with many diagnoses including liver failure and alcohol-induced dementia. 2/24/2020 - Admission MDS assessed R1 as having severe cognitive impairment. 3/4/2020 - In a Nurse Practitioner note, E7 (NP) documented that R1 was at the local emergency department the night prior due to change in mental status and being lethargic (difficult to awaken). His ammonia level (increases in liver failure and alcohol abuse) was being monitored and treated at the facility with two medications. An increase of ammonia in the body can lead to symptoms like loss of appetite, weakness, confusion, decreased alertness (lethargic), coma. (https://www.healthgrades.com/right-care/kidneys-and-the-urinary-system/elevated-blood-ammonia-level) 3/12/2020 - R7's (NP) progress note included that R1 was awake and talking. 3/14/2020 - The following sequence of events occurred: - R1's MAR recorded that the resident received his 6:00 AM dose of a medication to lower the ammonia level. - Medication Administration Audit Report showed that E6 (LPN) had checked R1's arm band placement at 10:31 AM and documented at 1:04 PM that the 9:00 AM were not given since R1 was hospitalized. R1 was not in the hospital during the 9:00 AM medication pass. - Transfer documents were printed with a time stamp of 11:04 AM.	F 842	subsequent events when the change in condition was first observed. Audit will also include checking for vital signs documentation prior to transfer and nurse(s) responsible for documentation. Education will be provided immediately for the nurse(s) with the lack of documentation. C. A root cause analysis was conducted, and it was determined that the root cause of the citation was related to the nurse sending out the resident did not complete the Situation-Background-Assessment Recommendation (SBAR) thoroughly to explain the subsequent event including the most recent vital signs prior to transfer. 1. All resident□s SBAR documentation during an acute care transfer will be reviewed by the Supervisor for completeness of information with special focus on subsequent event and most recent vital signs included. 2. Each day, during morning meeting and within 72 hours of transfer, SBAR will be reviewed by the management team for completeness. 3. QA review of readmission will also include the review of the SBAR during transfer for completeness. 4. Staff Development/Designee will educate all nursing staff regarding the completeness of the SBAR information focusing on subsequent events and the	

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ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

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F 842	Continued From page 11 - 6:54 PM SBAR form (electronic form documenting provider (MD, NP) contact about a change of condition) was completed by the nursing supervisor and included that R1 was lethargic and unable to take the medications scheduled for 9:00 AM. There were no current vital signs included. R1's responsible party was informed of the transfer at 12:00 PM (noon). -6:55 PM Nurses Notes: E6 (LPN) documented "Resident lethargic, confused. VS (vital signs) WNL (within normal limits)...BS (blood sugar) 110 (not low, low blood sugar can cause lethargy and confusion). Resident has history of alcoholic liver disease. Per [name of NP] order sent to ER via (by) 911 to [name of hospital] for eval (evaluation) and treatment." 10/13/2020 - Observation of the 9:00 med pass on the rehabilitation unit revealed E8 (LPN) arrived at the room that R1 had been residing at the time of the event around 10:40 AM. 10/14/2020 at 12:15 PM) - During an interview E2 (DON) confirmed the missing documentation. The facility failed to accurately document R1's change of condition and subsequent events. There was no evidence of the time the resident was found to be lethargic during the 9:00 AM medication pass. Review of vital signs found no recording of R1's blood pressure, heart rate, respiration or temperature at the time the change of condition was discovered. It was not clear when the NP was called or when R1 was picked up by the ambulance. Review of hospital records revealed blood tests were completed in the emergency department at 12:22 PM.	F 842	most recent vital signs. D. The DON or Designee will conduct daily audit of the SBAR completion of all residents transferred to an acute care setting x 1 week days until a 100% compliance is achieved. Following will be a weekly audit x 4 weeks of SBAR completion of all residents transferred to an acute care setting. Audits will continue monthly x 2 of SBAR completion of all residents transferred to an acute care setting until a 100% compliance is sustained. In an event where continued non-compliance is observed, facility will review and revise plan of correction to sustain compliance. Findings will be reviewed in the QAPI meetings monthly x 3 months.	

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 10/14/2020

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) COMPLETION DATE
F 842	Continued From page 12	F 842		

Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (QA) on 10/14/2020 during the exit conference beginning around 3:00 PM.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office 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 Rehabilitation & Health Center DATE SURVEY COMPLETED: October 14, 2020

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from October 13, 2020 through October 14, 2020. 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 one hundred forty-three (143). The survey sample totaled ten (10) plus three (3) additional subsampled residents.	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.	
3201	**Regulations for Skilled and Intermediate Care 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 October 14, 2020: F623, F694 and F842.	Cross refer to the CMS 2567-L survey completed October 14, 2020: F623, F694 and F842.	12/11/20

Provider's Signature _____ Title NHA Date 11/5/20

ASPEN

SEVERITY/SCOPE GRID

Name: ATLANTIC SHORES REHABILITATION & HEALTH CENTER
231 SOUTH WASHINGTON STREET
MILLSBORO, DE 19966

Provider 085037

Survey Date 10/14/2020

Survey Event ID: 0UYH11

Survey Types Complaint Investig.

SUMMARY OF DEFICIENCIES

Level 4	**J**	**K**	**L**
Level 3	**G**	**H**	**I**
Level 2	**D** F0623 F0694 F0842	**E**	**F**
Level 1	**A**	**B**	**C**

Jones, Tomeka N (DHSS)

From: Jones, Tomeka N (DHSS)
Sent: Thursday, November 5, 2020 9:58 AM
To: JPayne@healthASMA.com
Cc: Reed, Kim (DHSS); Smith, Robert (DHSS); Edwards, Melanie (DHSS); OHagan, Nancy (DHSS)
Subject: Atlantic Shores - Complaint survey ending on October 14, 2020
Attachments: Atlantic Shores_CV_PrvdrLtr_10-14-2020_Def.pdf; Atlantic Shores_CV_10-14-2020 _StRpt.docx; Plan of Correction Instructions 2013.docx

Categories: Egress Switch: Unprotected
Tracking:

Recipient	Delivery	Read
JPayne@healthASMA.com		
Reed, Kim (DHSS)	Delivered: 11/5/2020 10:00 AM	Read: 11/5/2020 10:34 AM
Smith, Robert (DHSS)	Delivered: 11/5/2020 10:00 AM	
Edwards, Melanie (DHSS)	Delivered: 11/5/2020 10:00 AM	
OHagan, Nancy (DHSS)	Delivered: 11/5/2020 10:00 AM	Read: 11/5/2020 10:40 AM

Switch-MessageId: f3e7077f5fc14ca68f4f5956cd621013

Good morning Mr. Payne Jr.,

Attached please find the ePOC directions, provider letter and state report for the Complaint survey ending on October 14, 2020. Located in ePOC, in the Aspen system; is the Federal 2567 Report, and another copy of the provider letter. Please acknowledge receipt of the 2567 in the ePOC system. **Please sign, complete and/or cross-reference, and date the State Report; returning to myself Tomeka Jones via email (tomeka.jones@delaware.gov) and Nancy O'Hagan (nancy.o'hagan@delaware.gov).**

Regards,

Tomeka

Tomeka Jones
Administrative Specialist I

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality - Long Term Care Residents Protection
3 Mill Road
Suite 308
Wilmington, DE
Mainline: (302) 421-7410
Office: (302)-421-7438
Fax: (302) 421-7401
Tomeka.Jones@delaware.gov

DELAWARE HEALTH
AND SOCIAL SERVICES
DIVISION OF HEALTH CARE QUALITY

November 5, 2020

Howard T. Payne, Jr.-Administrator
Atlantic Shores
231 South Washington St.
Millsboro, DE 19966-1236

RE: Atlantic Shores Complaint Survey ending October 14, 2020

Dear Mr. Payne Jr.:

I wish to thank your staff for the courtesy shown to the surveyor who conducted the Complaint Survey ending October 14, 2020. The survey findings show that your facility had federal participation requirements and state requirements that were not met. The Statement of Deficiencies (CMS-2567L) which provides specific details concerning federal requirements is in ePoC. The State Survey Report addressing state licensure requirements will be sent via email attachment.

Acceptable Plans of Correction (PoCs) for the deficiencies must be submitted, with the required signature, on the enclosed forms within ten (10) days of receipt of this letter. Failure to submit acceptable PoCs within ten days of receipt of this letter will result in recommendation to the Centers for Medicare & Medicaid Services (CMS) to impose remedies other than category 1 (one) and or denial of payment for new admissions effective as soon as notice requirements are met.

Your PoCs must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur; and
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

If you do not achieve substantial compliance within three months after the last day of the survey identifying noncompliance, CMS, must deny payments for new admissions. Also, CMS must terminate your provider agreement no later than six months from the last day of the survey if substantial compliance is not achieved by that time.

In accordance with 42 CFR 488.331 of the federal enforcement regulations, you are entitled to one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. To be given such an opportunity, you must submit a written request which identifies the specific deficiencies being disputed and includes the specific issues relating to the cited deficient practice with which you disagree. This written request must be received within the same ten-calendar day period that you have to submit your PoC. Written request should be submitted to me at the address listed on the letterhead. The IDR process is intended to be a continuous one from the time of survey until ten days after you have received the official CMS-2567L report.

If you believe these deficiencies have been corrected, you may contact me with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, CMS would not impose its federal remedies. However, if a revisit finds that you have not achieved substantial compliance; CMS has the right to impose federal remedies.

If you have any questions concerning the instructions contained in this letter, please contact me at (302) 421-7410.

Sincerely,

Robert H. Smith

Robert H. Smith
Licensing and Certification Administrator

RHS/tj

Enclosure

cc: Michele Clinton, RN, LTC Branch Manager, CMS, Certification and Enforcement
Jill McCoy, LTC Ombudsman
Richard McKee, DHCQ/OLTCRP
File