



DELAWARE HEALTH AND SOCIAL SERVICES

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

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT
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NAME OF FACILITY: Shipley Living
February 26, 2024

DATE SURVEY COMPLETED:

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>An unannounced Follow-Up Survey to the Complaint Survey ending January 8, 2024, was conducted at this facility from February 23, 2024 through February 26, 2024. The facility census the first day of the survey was 63. The survey sample totaled 17 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>No deficiencies were identified at the time of the survey.</p>		

Provider's Signature Eric Boide Title Executive Director Date 5-1-2024

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

PRINTED: 05/02/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/26/2024
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NAME OF PROVIDER OR SUPPLIER SHIPLEY LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 2723 SHIPLEY ROAD WILMINGTON, DE 19810
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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
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{F 000}	<p>INITIAL COMMENTS</p> <p>An unannounced Follow-Up Survey to the Complaint Survey ending January 8, 2024, was conducted at this facility from February 23, 2024 through February 26, 2024. The facility census on the first day of the survey was 63. The sample totaled 17 residents.</p> <p>The facility was found to have regained substantial compliance with 42CFR Part 483, Subpart B, Requirements for Long Term Care Facilities as of February 26, 2024.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/01/2024
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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.