



**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:** Ocean Grove Post Acute LLC

**DATE SURVEY COMPLETED:** April 1, 2026

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><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced complaint survey was conducted at this facility from March 31, 2026, through April 1, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 168. The sample totaled 3 residents.</p> <p><b>Regulations for Skilled and Intermediate Care Nursing Facilities</b></p> <p><b>Scope</b></p> <p><b>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.</b></p> <p>This requirement was not met as evidenced by:</p> <p>Cross Refer to the CMS 2567 – L survey completed April 1, 2026: cross refer: F657.</p>		

Provider's Signature Jimmy Hardy Faulstich Title NHA Date 5/1/2026

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  04/01/2026
NAME OF PROVIDER OR SUPPLIER  OCEAN GROVE POST ACUTE			STREET ADDRESS, CITY, STATE, ZIP CODE  231 SOUTH WASHINGTON STREET , MILLSBORO, Delaware, 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
F0000	INITIAL COMMENTS  An unannounced complaint survey was conducted at this facility from March 31, 2026 through April 1, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 168. The sample totaled (three) 3 residents.	F0000		04/17/2026
F0657 SS = D	Care Plan Timing and Revision  CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans  §483.21(b)(2) A comprehensive care plan must be:  (i) Developed within 7 days after completion of the comprehensive assessment.  (ii) Prepared by an interdisciplinary team, that includes but is not limited to--  (A) The attending physician.  (B) A registered nurse with responsibility for the resident.  (C) A nurse aide with responsibility for the resident.  (D) A member of food and nutrition services staff.  (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.  (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.  (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F0657	The facility cannot retroactively correct this issue. Resident expired.  Active Residents Code Status care plan was audited on 4/21/2026 to ensure care plan matches current code status order.  A review of the current Care Plan Updates/Revisions process was completed. It was determined that code status order and care plan being updated recently and prior care plan not being resolved was the root cause.  The IDT will review the changes/updates to code status in daily clinical meetings & Social Services Director/Designee will update the care plan when changes/updates are identified through the Nurse's 24 Hour Report/Electronic Records.  At that time the team will ensure duplicates are removed from Care Plan.  Social Workers & licensed nursing staff will be provided education by Wayne Slate/DON/Designee on updating/revision of care plans especially those related to code status by 4/24/2026  D) Staff will implement and monitor reviews of care plans related to code status. Updates/revisions will be conducted during the morning clinical meetings with IDT of current residents/ new admissions.  Audits will be conducted by DON/Designee Daily X5	05/05/2026

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 reverse for further 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.

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