

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

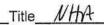
STATE SURVEY REPORT Page 1

NAME OF FACILITY: <u>Atlantic Shores Rehabilitation & Health Center</u> 2024

DATE SURVEY COMPLETED: March 4,

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE				
	An unannounced complaint survey was conducted at this facility from March 1, 2024, through March 4, 2024. The facility census the						
	first day of the survey was 160. The survey						
	sample totaled eight (8) residents. The survey process included observations, interviews,						
3201	review of residents' clinical records and other documentation as indicated.						
	Begulations for Skilled and Intermediate Con-						
3201.1.0	Regulations for Skilled and Intermediate Care Facilities						
3201.1.2	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.						

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Provider's Signature	Deale	Ilen



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 03/04/2024	
NAME OF PROVIDER OR SUPPLIER ATLANTIC SHORES REHABILITATION & HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE	
F 000	conducted at this fathrough March 4, 2 first day of the surv sample totaled eight process included of of residents' clinica documentation as it. No deficiencies were	complaint survey was acility from March 1, 2024 024. The facility census the ey was 160. The survey at (8) residents. The survey bservations, interviews, review I records and other	F 0	TITLE	(X6) DATE	

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.

Electronically Signed

03/13/2024