

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER Atlantic Shores Rehabilitation & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 231 South Washington Street Millsboro, DE 19966	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47142</p> <p>Based on observations, interviews and record review, it was determined that for one (R15) out of four residents reviewed for accident hazards, the facility failed to ensure the resident's environment was free of accident hazards. On 6/3/24, while being transported in the facility van, R15 fell from the wheelchair due to improper restraining. R15 was taken to the hospital for treatment of a cut to the forehead. The unsafe facility transport caused R15 harm. Findings include:</p> <p>An undated facility instruction guide titled Driver/Operator Instruction Guide QRT MAX included: Step 2. Attach lap and shoulder belt. Belt should bear upon the bony structure of the body and should be worn low across the front of the pelvis with the junction between the lap and shoulder belts located near the passenger's hip. Adjust the bets as firmly as possible consistent with user comfort.</p> <p>A review of R15's clinical record revealed:</p> <p>11/30/18 - R15 admitted to facility with diagnoses including but not limited to, hemiplegia and hemiparesis affecting the left side.</p> <p>4/29/24 - A quarterly MDS documented R15 had a documented BIMS score of 13, revealing an intact cognitive state. R15 was documented as requiring moderate assistance to change from sitting to standing position and to transfer from a bed to a wheelchair.</p> <p>6/3/24 4:57 PM - A hospital history and physical report by P1 (MD) documented that [R15] is a [AGE] year-old male who is wheelchair-bound . Apparently [R15] was traveling in the van and as per records seems like he was unrestrained in his wheelchair in the van. Apparently upon taking a sharp turn [R15] fell out of his wheelchair and in the process bumped his forehead. [R15] was brought to the emergency room as a trauma code. There is a small laceration on the forehead . Status post fall from the wheelchair: Patient has been evaluated by trauma. CT of head, neck, chest abdomen pelvis without any acute findings of trauma. Patient does have a minor scalp laceration and has been evaluated by surgery.</p> <p>6/4/23 1:25 PM - A nurses note by E9 (Nurse Unit manager) documented that R15 was admitted to [NAME] with symptomatic anemia and a scalp laceration [status post] fall .</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6/5/24 12:38 PM - A provider note by E11 (CRNP, APRN-C) documented that . [R15] seen after returning from hospital. He is returning here from an appointment with a specialist, fell out of his wheelchair and sustained a laceration to his forehead. He was taken to the ED. Imaging was negative for any acute injury .</p> <p>6/5/24 - A wound assessment report by E12 (Wound NP) documented that R15 had a 3.5 cm x 3.5 cm x 0.2 cm laceration to the scalp with the appearance of 75-99% epithelial cells and 1-24% eschar. The treatment was to cleanse with normal saline and apply xeroform or a bordered gauze every day or as needed.</p> <p>6/6/24 2:39 PM - An observation of R15 revealed a wound dressing to the left forehead and a standard sized wheelchair in the room next to the bed. In an interview with R15, he was unable to recall any specific details of the incident on 6/3/24.</p> <p>6/6/24 2:58 PM - An interview with E13 (Van Driver) revealed that she was driving R15 to an appointment on 6/3/24 and she secured the hooks to the wheelchair frame and secured the lap belt to the floor anchor then through the wheelchair's armrests and anchored to the floor on the opposite side appropriately. E13 stated that along the way she drove around a roundabout and looked up in the rearview mirror at R15 who had his eyes closed, calm and was slightly hunched over. E13 had driven around a second roundabout and heard a bang. E13 looked over her shoulder and saw R15's whole body on the floor with the lap belt on him. E13 stated that she saw blood on the floor and a cut on R15's head and didn't touch or move R15. E13 stated during her initial training, the maintenance director showed her the lap belt but could not remember being shown the shoulder belt. E13 stated that the shoulder belt doesn't really do anything.</p> <p>6/6/24 3:20 PM - An observation made with E13 in the same transport van used during the incident when E13 demonstrated where the wheelchair was placed and the position of R15 after the fall. E13 stated R15 was between the right side of the wheelchair and the right sliding passenger door of the van. R15's head was towards the back of the van and his feet were towards the front. E13 stated that R15 must have hit his head on one of the floor anchors.</p> <p>6/10/24 10:33 AM - An interview with P2 (EMT) revealed that R15 was laying on the floor of the transport van between the wheelchair and the right sliding passenger door of the van. R15's head was towards the back of the van and feet were towards the front of the van. R15 was in a fetal position with an injury to the head that was bleeding. P2 stated that there was no lap belt of any kind on the resident when they arrived and they did not have to unbuckle any belts to remove the resident onto a stretcher.</p> <p>The facility failed to safely restrain R15 in the transport van which resulted in R15 falling out of the wheelchair where he hit his head and was transported to the hospital.</p> <p>6/10/24 2:40 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA and IP) and E4 (Regional Consultant) during the exit conference.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>40260</p> <p>Based on record review, interview and review of other facility documentation, it was determined that in accordance with accepted professional standards and practices, the facility failed to maintain the Controlled Drug Count Record report accurately and completely for the month of May 2024. The facility did not accurately reconcile the transfer of controlled drugs from one shift to another. Findings include:</p> <p>Review of the Controlled Drug Count Record report for the month of May 2024 revealed the following:</p> <p>5/2/24 - 3:00 PM - 11:00 PM shift lacked evidence that the narcotic count was completed for Nurse Reporting On and there was no entry for Received From Pharmacy (+).</p> <p>5/3/24 - 11:00 PM - 7:00 AM shift lacked evidence that the narcotic count was completed for Nurse Reporting On.</p> <p>5/7/24 - Under the 3:00 PM - 7:00 AM shift, the Received from Pharmacy (+) number was scribbled out and it appears that it was initially marked as 0 and then changed to 1.</p> <p>5/8/24 - Under the 11:00 PM - 7:00 AM shift the following categories were not completed: Completed/Disposed (-), Received from Pharmacy (+) and # Items in Drawer.</p> <p>5/9/24 - Under the 11:00 PM - 7:00 AM shift, the following categories were not completed: Nurse Reporting ON (11-7), Completed/Disposed (-), Received from Pharmacy (+) and # Items in Drawer.</p> <p>5/10/24 - No one signed under Nurse Reporting OFF (11-7) or recorded the number of items in the drawer. Additionally, under the 3:00 PM - 11:00 PM shift, someone marked over 0 with a 1, making the entry difficult to decipher. Under 11:00 PM - 7:00 AM shift the following categories were not completed: Completed/Disposed (-), Received from Pharmacy (+) and # Items in Drawer.</p> <p>5/11/24 - Under the 7:00 AM - 3:00 PM shift, at the beginning of the shift, there were 21 items with nothing received or disposed of, yet it appears that the number of items in the drawer is 20. Under the 3:00 PM - 11:00 PM shift, the number of items in the drawer was written over, making the number difficult to decipher.</p> <p>5/13/24 - Under the 11:00 PM - 7:00 AM shift, it appears that the number 2 was entered and then written over with a 0, making the entry difficult to decipher.</p> <p>5/15/24 - Under the 3:00 AM - 11:00 PM shift, the following categories were not completed: Nurse Reporting On 3-11, # Items in Drawer (both oncoming and off going), Completed/Disposed (-), and Received from Pharmacy (+).</p> <p>6/7/24 1:35 PM - In an interview, E1 (NHA) and E2 (DON) confirmed that the facility did not accurately reconcile the transfer of controlled drugs from one shift to another.</p> <p>(continued on next page)</p>		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/10/24 2:40 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA and IP) and E4 (Regional Consultant).		