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 07/18/2024
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)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47621 Based on record review and interview, it was determined that for one (R146) out of three residents reviewed for beneficiary notice, the facility failed to provide notification of service changes to R146's authorized representative. Findings include: Review of R146's clinical record revealed: 3/30/24 - R146 was admitted to the facility. 4/5/24 - R146's admission MDS assessment documented a BIMS score of three, which reflected severe cognitive impairment. 4/12/24 - R146 given a Notice of Medicare Non-Coverage (NOMNC) that advised that R146's effective date of last day of Medicare coverage was 4/17/24. The document was signed by E44 (Social Work) and E43 (Business Office manager) with the statement unable to sign BIM of 3 written in box beneath the statement Signing below means that you've received and understand this notice . 7/9/24 1:54 PM - During a telephone interview, F2 (R146's sister) stated that she was not informed about R146's last day of Medicare coverage and was not offered the opportunity to appeal. 7/10/24 3:20 PM - A review of R146's face sheet revealed that R146 listed as responsible party and F2 (R146's sister) listed as emergency contact #1 and F3 (R146's other sister) listed as emergency contact #2. The facility was unable to provide evidence of any attempt to reach either emergency contact for the purpose of receiving the NOMNC notification. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46988 Based on observation and interview, it was determined that for one out of five resident units, the facility failed to provide a clean and homelike environment. Findings include: 7/9/24 10:13 AM - An observation in the 300 hallway of Ocean Gardens unit, revealed a broken handrail with jagged edges not covered. The baseboards in 400 hallway were dirty and dusty, and an area where a dark substance was spilled on wall with a stain. Subsequently the same observation occurred on 7/10/24 and 7/11/24. 7/12/23 1:00 PM - An interview with E13 (Maintenance Director) revealed that the facility has a plan to replace all handrails with new design. E13 stated he will cover the broken handrail for safety concerns for the current time until new rails are installed. E13 also stated that maintenance will clean the base boards and wall of the 400 hallway. 7/15/24 9:51 AM - An observation of a handrail in the 300 hallway of Ocean Gardens unit, revealed a broken handrail with jagged edges not covered. The baseboards in 400 hallway were dirty and dusty, and an area where a dark substance was spilled on wall with a stain. 7/15/24 2:17 PM - An interview with E13 confirmed the handrail should have been fixed over the weekend and it will get taken care of today. Also noted the walls and base boards will be cleaned today. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 47621 Based on record review and interview, it was determined that for one (R146) out of three residents reviewed for abuse, the facility failed to protect R146 from misappropriation of resident property/funds. Findings include: Review of R146's clinical record revealed: 3/30/24 - R146 was admitted to the facility. 4/5/24 - R146's admission Minimum Data Set (MDS) assessment documented R146's BIMS score of three, which reflected severe cognitive impairment. 4/12/24 - A Notice of Medicare Non-Coverage (NOMNC) documented that R146's last day of Medicare coverage was 4/17/24. The document was signed by E44 (Social Worker) and E43 (Business Office manager) with the statement unable to sign BIM of 3 written in box beneath the statement Signing below means that you've received and understand this notice . 5/16/24 - According to a signed and dated statement, F2 (R146's sister) provided the facility with R146's identification, bank statement, other documents and R146's checkbook. F2 had E1 (NHA) and E5 (SW Director) sign the document listing all the documents and belongings that F2 handed over to the facility. 5/17/24 11:05 AM - E43 (Business Office manager) documented a note in R146's EMR that stated R146's checkbook and other documents were secured in the facility safe. 5/19/24 3:43 PM - E45 (RN) documented in R146's EMR that a family member called and requested that R146 should not sign anything without her family present. 5/23/24 - E1 (NHA) and E43 (Business Office manager) obtained R146's checkbook from the facility safe and assisted R146 to write two checks- Check #4483 to the facility in the amount of $6435 for April room/Board and another check as deposit for an assisted living facility that R146 was interested in transferring to. The facility failed to identify that R146 was not cognitively capable of understanding a financial transaction and failed to safeguard R146's property from inappropriate access. 5/29/24 - E46 (Psychologist) documented in R146's EMR, Her judgment and insight are impaired. At this time, pt is not capable of making her own healthcare decisions. 5/31/24 - E43 received an email from the facility Home Office stating that check #4483 was returned for insufficient funds. 5/31/24 - The facility made a referral for capacity determination. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/3/24 - E39 (MD) completed a Physician Affidavit for Guardianship which documented that R146 does not have capacity. 7/12/24 9:31 AM - During an interview, E44 (SWS) stated, When I was explaining about the insurance, she did not understand. She did not understand what she was signing so she did not sign. She would nod her head in agreement but she did not understand. 7/12/24 9:55 AM - During an interview, E43 stated, Only the NHA and I have access to the safe. The NHA and I took her checkbook to her to write the checks (to [assisted living facility] and to us). That is when we found out the money was gone because the checks bounced . I told the NHA and Social worker was to report it to APS (Adult Protective Services). The facility was unable to provide evidence that this allegation of missing resident funds was reported to the State agency. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47621 Based on record review and interview, it was determined that for one (R146) out of three residents reviewed for abuse, the facility failed to immediately recognize and report an allegation of financial exploitation. Findings include: Review of R146's clinical record revealed: 3/30/24 - R146 was admitted to the facility. 4/5/24 - R146's admission Minimum Data Set (MDS) assessment documented R146's BIMS score of three, which reflected severe cognitive impairment. 5/16/24 - F2 (R146's sister) provided the facility with R146's identification, bank statement, checkbook and other documents. F2 had E1 (NHA) and E5 (SW Director) sign a document listing all the documents and belongings that F2 had handed over to the facility. The February 2024 bank statement documented that R146 had $34,642.75 in her checking account. 5/17/24 11:05 AM - E43 (Business Office manager) documented a note in R146's EMR that stated R146's checkbook and other documents were secured in the facility safe. 5/19/24 3:43 PM - E45 (RN) documented in R146's EMR that a family member called and requested that R146 should not sign anything without her family present. 5/23/24 - E1 and E43 obtained R146's checkbook from the facility safe and assisted R146 to write two checks- Check #4483 to the facility in the amount of $6435 for April room/Board and another check as deposit for an assisted living facility that R146 was interested in transferring to. 7/12/24 9:55 AM - During an interview, E43 stated, Only the NHA and I have access to the safe. The NHA and I took her checkbook to her to write the checks (to [assisted living facility] and to us). That is when we found out the money was gone because the checks bounced . I told the NHA and Social work (sic) was to report it to APS (Adult Protective Services). 7/12/24 11:03 AM- During an interview, E1 (NHA) stated, We were trying to get the Medicaid application together. When we got the bounced check, that is when we became aware that there was a problem. That was sometime in May . No, I did not report it . 7/15/24 3:35 PM - During an interview, E43 stated, We got an email from Home Office stating that the check had bounced on 5/31/24. 7/15/24 5:30 PM - After inquiry from the surveyor, E2 (DON) reported the check situation to the local police. The report number is 84-24-002245. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46988 Based on observation, interview and record review it was determined that for two (R123 and R143) out of three residents reviewed for bowel and bladder, the facility failed to respond to or provide services to restore bladder continence. Findings include: 1. Review of R123's clinical record revealed: 2/15/24 - R123 was admitted to the facility. 2/20/24 - A bowel and bladder initial assessment revealed that R123 was continent of bowel and bladder. 2/21/24 - An admission MDS assessments revealed that R123 was always continent of bowel and bladder and not indicated for a toileting program. April 2024 - A review of the April CNA task flow sheet revealed that R123 was incontinent of bladder sixty-five times out of ninety opportunities. 5/21/24 - A quarterly MDS assessment revealed that R123 was frequently incontinent of bladder and always incontinent of bowel and not indicated for a toileting program. May 2024 - A review of the May CNA task flow sheet revealed that R123 was incontinent of bladder seventy-two times out of ninety opportunities. June 2024 - A review of the June CNA task flow sheet revealed that R123 was incontinent of bladder eighty-[NAME] times out of ninety opportunities. July 2024 - A review of the July CNA task flow sheet revealed that R123 was incontinent of bladder twenty-nine times out of thirty-three opportunities. 7/15/24 12:53 PM - An interview with E40 (CNA) confirmed that R123 is usually incontinent and unable to recall if R123 was on a toileting program. E40 stated that R123 was on a different unit previously and was using a urinal. E40 stated she does not offer a urinal or commode to R123. 7/15/24 1:45 PM - An interview with E41 (COTA) confirmed that therapy assessed R123 for use of urinal and bedside commode. E41 confirmed that R123 is able to utilize both adaptive equipment safely. 7/16/24 12:19 PM - An interview with E14 (RN Staff Educator) revealed that the voiding diary gives them an idea of target times to assist the resident with incontinence. Nursing is able to initiate adaptive equipment such as a urinal but therapy has to initiate a commode. E14 confirmed that R123 is not currently using a urinal or commode. The facility lacked evidence of responding to decreased continence and failed to provide evidence of services to restore continence for R123. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/16/24 1:20 PM - An interview with E3 (QA), E7 (ADON), and E2 (DON) revealed that R123 was offered a urinal trial starting on 7/15/24. 2. Review of R143's clinical record revealed: 4/4/24 - R143 was admitted to the facility. 4/6/24 - An admission MDS revealed that R143 is occasionally incontinent of bowel and bladder and is not indicated for a toileting program. April 2024 - A review of the April CNA task flow sheet revealed that R143 was incontinent of bladder fifty-nine out of one hundred and one opportunities. May 2024 - A review of the May CNA task flow sheet revealed that R143 was incontinent of bladder eighty-three out of one hundred and twenty-six opportunities. June 2024 - A review of the June CNA task flow sheet revealed that R143 was incontinent of bladder fifty-five out of ninety opportunities. July 2024 - A review of the July CNA task flow sheet revealed that R143 was incontinent of bladder twenty-eight out of thirty-eight opportunities. 7/5/24 - A voiding diary was completed for R143 from 7/3/24 to 7/5/24. The facility lacked evidence of implementing a plan to restore continence for R143. 7/17/24 10:25 AM - An interview with E20 (CNA) revealed that [R143] is independent and will notify staff if she is incontinent. [R143] is able to clean herself up and I (E20) dont normally have to assist her. The facility lacked evidence of responding to decreased continence and failed to provide evidence of services to restore continence for R143. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 38302 Based on observation and interview, it was determined that the facility failed to maintain a safe and sanitary environment for staff. Findings include: 7/9/24 12:17 PM - Several pipes in the ceiling area of the clean laundry room were dripping onto the floor and into a trash can that had been placed under a portion of the leaking area. All of the leaking pipes had numerous areas of black staining, which appeared fuzzy in some sections. Three wet and stained towels were on the floor under the areas of the leaks. 7/9/24 1:46 PM - During an interview, E50 (Laundry Staff) confirmed the dripping and standing water and stated that the water had been dripping from the pipes and pooling on the floor for several months. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.