DELAWARE HEALTH AND SOCIAL SERVICES Division of Health Care Quality

DHSS - DHCQ 263 Chapman Road, Suite 200, Cambridge Bldg. Newark, Delaware 19702 (302) 421-7400

STATE SURVEY REPORT

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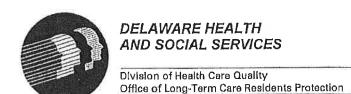
NAME OF FACILITY: Harbor Chase of Wilmington

Office of Long-Term Care Residents Protection

DATE SURVEY COMPLETED: April 7, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual and Complaint survey was conducted at this facility begin ning March 31, 2025, and ending April 7, 2025. The facility census on the entrance day of the survey was 102 (one hundred two) residents. The survey sample was composed of thirteen (13) residents and a subsample survey of an additional ten (10) residents. The survey process included observations, interviews, review of resident clinical records, facility documents and facility policies and procedures, and complaint and incident documentation from the State Agency. Abbreviations/definitions used in this state report are as follows: BOM — Business Office Manager; DMC — Director of Memory Care; DOH — Director of Momory Care; DOM — Director of Maintenance; DOMC — Director of Memory Care; DOS — Director of Resident Care; ED — Executive Director; LPN - Licensed Practical Nurse;		
3225	RN - Registered Nurse. Assisted Living Facilities	,) ·
3225.7.0	Specialized Care for Memory Impairment		
3225,7.3	The information disclosed shall explain the additional care that is provided in each of the following areas:		
3225.7.3.2	Resident Population: a description of the resident population to be served; the service agreement and its implementation;		

Provider's Signature The Executive DRENTO, Date 5/1/25



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NAME OF FACILITY: Harbor Chase of Wilmington

Provider's Signature _____

DATE SURVEY COMPLETED: April 7, 2025

SECTION STA	ATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.7.3.3	Pre-Admission, Admission & Discharge the process and criteria for placemen transfer or discharge from this specialize care;	t,	MARINE THE STREET STREET
3225.7.3.4	Assessment, Care Planning & Implementation: the process used for assessment and establishing and updating the service agreement and its implementation,		
3225.7.3.5	Staffing Plan & Training Policies: staffing plan, orientation, and regular in-service education for specialized care;		
3225.7.3.6	Physical Environment: the physical envi- ronment and design features, including	No residents were affected by this practice.	5/25/2025
S/S - E	security systems, appropriate to support the functioning of adults with memory impairment; This requirement was not met as evidenced by: Based on policy review, interview and review of other facility documentation, it was determined that the facility lacked some specific MC policy and procedures for disclosure to those persons seeking specialized care for memory impairment. Findings include: 4/7/25 — The facility Policy and Procedure manuals, Memory Care marketing brochures and Resident Agreement packets were reviewed. There was evidence of some specific MC information, however the following regulations: 7.3.3 Pre-Admission, admission and discharge, 7.3.4 As-	 All memory care residents had the potential to be affected by this practice. All current memory care residents and their responsible parties will be notified and receive a copy of the marketing material specific to MC information as required by state regulations to ensure substantial compliance. The ED will in-serviced the sales team on the process related to having a perspective resident and responsible party on the process to inform them of the special services that the community(HCW) provides in the memory care unit. The ED or designee will audit 	

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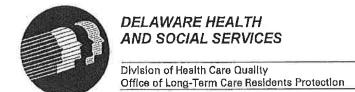
NAME OF FACILITY: Harbor Chase of Wilmington

Provider's Signature ___

DATE SURVEY COMPLETED: April 7, 2025 STATEMENT OF DEFICIENCIES ADMINISTRATOR'S PLAN FOR Completion SECTION SPECIFIC DEFICIENCIES CORRECTION OF DEFICIENCIES WITH Date ANTICIPATED DATES TO BE CORRECTED sessment, care planning and implementahave received and signed the doction, 7.3.5 Staffing plan and training poliumentation related to Memory cies of the staff and 7.3.6 The physical encare specific policies and procevironment referencing the security sysdures prior to admission. Audits tems were not in evidence. will be conducted weekly for 4/7/25 - Per interview with E6 (DOS) at apthree weeks, then monthly times proximately 9:50 AM, E6 confirmed the two months or until 100% compliwritten information was not in evidence. ance is achieved. Policy and pro-E6 stated the information is shared vercedures have been reviewed, and bally when persons seeking admission are no changes were necessary to on tour of the facility. achieve regulatory compliance. 4/7/25 - Findings were reviewed with E1 4. Findings will be reported during (ED) and E2 (DRC) at the exit conference, the monthly QAPI meeting for rebeginning at approximately 2:30 PM. view and recommendations. The Staffing 3225,16.0 frequency of the audits and adjusted according to outcomes. A staff of persons sufficient in number 3225.16.2 and adequately trained, certifled or licensed to meet the requirements of the S/S-E residents shall be employed and shall comply with applicable state laws and regulations. 1. Nothing can be done for those State Of Delaware Board of Nursing-"RN 5/25/2025 residents previously assessed (registered nurse), LPN (licensed practical by an LPN after a fall. nurse) and NA (nurse's aide)/ UAP (unlicensed assistive personnel) Duties 2. Any resident who had a fall and 2024...Post Fall Assessment & Documenwas assessed by an LPN could tation-RN..." Updated 4/10/24. have been affected by this This requirement was not met as evipractice. denced by: 3. Nurses will be in serviced by the Based on record review, interview and re-DRC or designee that view of other facility and State documenit is not in the LPN scope of tation, It was determined that for seven practice that they can (R6, R7, R8, R10, R12, R15 and R17) out of assessed for injury after a fall. twenty-three sampled residents, an LPN, An RN must perform a post

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NAME OF FACILITY: Harbor Chase of Wilmington

DATE SURVEY COMPLETED: April 7, 2025

SECTION	TATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	not an RN as required by the Delaware	fall assessment if a resident	I
	State regulation of the Board of Nursing	does not go to a higher level	4
	Scope of Practice, completed a resident's	of care for assessment. In	
	post fall assessment. Findings include:	order to achieve compliance,	
	1. 12/16/24 - R6 was admitted to the facil-	the physician services that	
	ity. A review of R6's fall incident report re-	11	V.
	vealed the following fall assessment was	agreed to provide telehealth	
	completed by an LPN, not an RN as re-	assessments on all residents	
	quired by the Delaware State regulation of	who consent to this service if	a.
	the Board of Nursing Scope of Practice.	an RN is not available in the	
		facility. If a resident/family	
	- 3/12/25 at 10:37 AM	member does not consent to	-
	2. 8/31/24 - R7 was admitted to the facil-	this service, then the resident	
	ity. A review of R7's fall incident report re-	will be sent to the emergency	
	vealed the following fall assessment was	room for assessment if an RN	
	completed by an LPN, not an RN as re-	is not available. The ED or de	
	quired by the Delaware State regulation o	signee will audit 100% of incl	"
	the Board of Nursing Scope of Practice.	dent reports to ensure an ap	
	- 11/25/24 at midnight	propriate RN or physician as	8
		assessment of a resident who	
	3. 8/8/23 - R8 was admitted to the facility	has experienced a fall weekly	348
	A review of R8's fall incident reports re-	for two months and then	
	vealed the following fall assessments were	monthly times one month	
	completed by an LPN, not an RN as re-	tl 4000/lt.u.a.la	
	quired by the Delaware State regulation of the Board of Nursing Scope of Practice.	achieved. Policy and proce-	
	the board of Nursing Scope of Fractice.	dures have been reviewed,	
S	- 2/5/25 at 8:52 PM	and no changes were neces-	
	- 2/28/25 at 10:15 AM	sary to achieve regulatory	
		compliance.	
	- 2/28/25 at 4:00 PM		
	- 3/25/25 at 7:45 PM	4.Findings will be reported	
	4. 6/24/24 – R10 was admitted to the facil	during the monthly QAPI	
	ity. A review of R10's fall incident reports	meeting for review and	
- 1	revealed the following fall assessments	recommendations. The	
	were completed by an LPN, not an RN as	frequency of the audits and	
		adjusted according to out	

Provider's Signature		Title	Date
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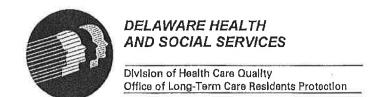
NAME OF FACILITY: Harbor Chase of Wilmington

Office of Long-Term Care Residents Protection

DATE SURVEY COMPLETED: April 7, 2025

SECTION STA	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
		CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED comes.	
	7. 9/25/23 - R17 was admitted to the facility. A review of R17's fall incident reports revealed the following fall assessments were completed by an LPN, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice 2/16/25 at 5:00 AM		

Provider's Signature		Title	Date
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NAME OF FACILITY: Harbor Chase of Wilmington

DATE SURVEY COMPLETED: April 7, 2025

- 2/19/25 at 6:30 AM 4/1/25 – Per an interview with E10 (LPN) at approximately 2:42 PM, E10 stated that for resident falls that will not result in hos- pital transfers, the LPNs complete the as- sessments. E10 stated that the DRC comes in the following day to review the care plan and sign the assessment off. 4/2/25 11:24 AM – During an interview, E2 (DRC) confirmed that the LPNs have been completing the fall assessments. 4/7/25 - Findings were reviewed with E1 (ED) and E2 at the exit conference, begin- ning at approximately 2:30 PM. Records and Reports Reportable incidents shall be reported im-	SECTION	TEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
mediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division. Reportable incidents include: Death of a resident in a facility or within 5 days of transfer to an acute care facility. S/S - D This requirement was not met as evidence by: Based on a review of medical records, interview, the facility and the Division documentation, it was determined that for two (R14 and R18) out of five residents sampled for death reporting, the facility failed to report the death per the State regulation of within 8 hours. Findings include: No fesidents were affected by the late reporting. 1. No fesidents were affected by the practice before the survey. The two residents cited were the only residents whose deaths were reported late. No residents were affected by this practice. 3. Nurses were in serviced by DRC at meetings 3/25/2025 and 3/26/25 on the reporting requirements for a death. processes were reviewed and system changes are necessary for regulatory compliance. Nurse to notify DRC or ED of any deaths and confirm reporting status to them and DRC or designee will complete	3225.19.0 3225.19.6 3225.19.7 3225.19.7.6	- 2/19/25 at 6:30 AM 4/1/25 — Per an interview with E10 (LPN) at approximately 2:42 PM, E10 stated that for resident falls that will not result in hospital transfers, the LPNs complete the assessments. E10 stated that the DRC comes in the following day to review the care plan and sign the assessment off. 4/2/25 11:24 AM — During an interview, E2 (DRC) confirmed that the LPNs have been completing the fall assessments. 4/7/25 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 2:30 PM. Records and Reports Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division. Reportable incidents include: Death of a resident in a facility or within 5 days of transfer to an acute care facility. This requirement was not met as evidence by: Based on a review of medical records, interview, the facility and the Division documentation, it was determined that for two (R14 and R18) out of five residents sampled for death reporting, the facility failed to report the death per the State regula-	 No residents were affected by the late reporting. The facility had self-identified this practice before the survey. The two residents cited were the only residents whose deaths were reported late. No residents were affected by this practice. Nurses were in serviced by DRC at meetings 3/25 /2025 and 3/26/25 on the reporting requirements for a death. processes were reviewed and system changes are necessary for regulatory compliance. Nurse to notify DRC or ED of any deaths and confirm reporting status to them 	

Provider's Signature	Title	Date



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		DATE SURVEY CONIPLETED:	April 1, Lozo
SECTION	ATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	1. 10/24/18 – R14 was admitted to the hospital. R14 expired on 3/7/25 at 11:00 AM. Per the State Agency Reporting System record, the facility reported the dear on 3/13/25 at 3:16 PM, six days later and not within the eight-hour reporting regultion. 2. 1/1/23 – R18 was admitted to the hospital. R18 expired on 9/12/24 at 9:25 PM. Per the State Agency Reporting System record, the facility reported the death on 9/13/24 at 12:53 PM, over the eight-hour reporting regulation. 4/7/25 – Per interview with E2 (DRC) at a proximately 2:00 PM, E2 confirmed the late reporting of these two deaths. 4/7/25 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 2:30 PM.	ports of occurring death of residents at facility. Policy and procedures have been reviewed, and no changes were necessary to achieve regulatory compliance. 4. Findings will be reported during the monthly QAPI meeting for review and recommendations. The frequency of the audits and adjusted according to outcomes.	

Provider's Signature The And Executive Diaceton Date 5/1/25