DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Harbor Chase of Wilmington

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 beginning 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 Hospitality; DOM – Director of Maintenance; DOMC – Director of Memory Care: DOS – Director of Sales; DRC - Director of Resident Care; ED – Executive Director; LPN -Licensed Practical Nurse; RN – Registered Nurse.		
3225	**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 [signature] Title Executive Director Date 5/1/25

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3225.7.3.3 3225.7.3.4 3225.7.3.5 3225.7.3.6 S/S - E	**Pre-Admission, Admission & Discharge: the process and criteria for placement, transfer or discharge from this specialized care;** **Assessment, Care Planning & Implementation: the process used for assessment and establishing and updating the service agreement and its implementation,** **Staffing Plan & Training Policies: staffing plan, orientation, and regular in-service education for specialized care;** **Physical Environment: the physical environment and design features, including 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-	1. No residents were affected by this practice. 2. 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. 3. 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 100% of newly admitted residents and responsible party that are being admitted to Memory Care	5/25/2025

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	sessment, care planning and implementation, 7.3.5 Staffing plan and training policies of the staff and 7.3.6 The physical environment referencing the security systems were not in evidence. 4/7/25 - Per interview with E6 (DOS) at approximately 9:50 AM, E6 confirmed the written information was not in evidence. E6 stated the information is shared verbally when persons seeking admission are on tour of the facility. 4/7/25 - Findings were reviewed with E1 (ED) and E2 (DRC) at the exit conference, beginning at approximately 2:30 PM.	have received and signed the documentation related to Memory care specific policies and procedures prior to admission. Audits will be conducted weekly for three weeks, then monthly times two months or until 100% compliance is achieved. 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.	
3225.16.0 3225.16.2 S/S – E	**Staffing** **A staff of persons sufficient in number and adequately trained, certified or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations.** **State Of Delaware Board of Nursing- "RN (registered nurse), LPN (licensed practical nurse) and NA (nurse's aide)/ UAP (unlicensed assistive personnel) Duties 2024...Post Fall Assessment & Documentation- RN..." Updated 4/10/24.** **This requirement was not met as evidenced by:** Based on record review, interview and review of other facility and State documentation, it was determined that for seven (R6, R7, R8, R10, R12, R15 and R17) out of twenty-three sampled residents, an LPN,	1. Nothing can be done for those residents previously assessed by an LPN after a fall. 2. Any resident who had a fall and was assessed by an LPN could have been affected by this practice. 3. Nurses will be in serviced by the DRC or designee that it is not in the LPN scope of practice that they can assessed for injury after a fall. An RN must perform a post	5/25/2025

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	not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice, completed a resident's post fall assessment. Findings include: 1. 12/16/24 - R6 was admitted to the facility. A review of R6's fall incident report revealed the following fall assessment was completed by an LPN, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. - 3/12/25 at 10:37 AM 2. 8/31/24 - R7 was admitted to the facility. A review of R7's fall incident report revealed the following fall assessment was completed by an LPN, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. - 11/25/24 at midnight 3. 8/8/23 - R8 was admitted to the facility. A review of R8'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. - 2/5/25 at 8:52 PM - 2/28/25 at 10:15 AM - 2/28/25 at 4:00 PM - 3/25/25 at 7:45 PM 4. 6/24/24 – R10 was admitted to the facility. A review of R10's fall incident reports revealed the following fall assessments were completed by an LPN, not an RN as	fall assessment if a resident does not go to a higher level of care for assessment. In order to achieve compliance, the physician services that Harbor Chase uses have agreed to provide telehealth assessments on all residents who consent to this service if an RN is not available in the facility. If a resident/family member does not consent to this service, then the resident will be sent to the emergency room for assessment if an RN is not available. The ED or de signee will audit 100% of incl dent reports to ensure an ap propriate RN or physician as assessment of a resident who has experienced a fall weekly for two months, and then monthly times one month until 100% compliance is achieved. 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 out	

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	required by the Delaware State regulation of the Board of Nursing Scope of Practice. - 12/7/24 at 7:10AM - 12/18/24 at 5:45 AM - 12/18/24 at 11:21 PM - 1/5/25 at 2:30 AM - 2/12/25 at 10:20 AM 5. 12/2/24 - R12 was admitted to the facility. A review of R12's fall incident report revealed the following fall assessment was completed by an LPN, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice. - 1/11/25 at 4:14 AM 6. 7/29/22 - R15 was admitted to the facility. A review of R15'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. - 11/19/24 at 3:18 AM - 12/7/24 at 9:00 PM - 12/11/24 at 11:00 PM 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	comes.	

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	- 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.		
3225.19.0 3225.19.6 3225.19.7 3225.19.7.6 S/S – D	**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 regulation of within 8 hours. Findings include:	1. No residents were affected by the late reporting. 2. 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. 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 the five-day follow-up under the	5/25/2025

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	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 death on 3/13/25 at 3:16 PM, six days later and not within the eight-hour reporting regulation. 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 approximately 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.	new Wellsky system. ED or designee will audit reportable weekly x 4 then monthly x 2 or till audits are 100% compliant for timely reports 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 _____ Title Executive Director Date 5/1/25